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No. 00-

IN THE

Supreme Court of the United States

JIMMY WALLACE MCNEIL,
as Independent Executor and Representative of the Estate of Michael Jay McNeil,

Petitioner,

v.

TIME INSURANCE COMPANY,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether Title III of the Americans with Disabilities Act, 12 U.S.C. § 12182, applies to discriminatory policy terms limiting insurance coverage sold by public accommodations?

2. Whether ERISA applies to and preempts petitioner's claims based on state-law duties otherwise applicable to the content of all health insurance sold in Texas and in this case sold in a context having no connection with the interstate labor market?

PARTIES TO THE PROCEEDINGS BELOW

Plaintiff-appellant below, and petitioner in this Court, is Jimmy Wallace McNeil, as Independent Executor and Representative of the Estate of Michael Jay McNeil.

Also appearing as plaintiffs below were Michael Jay McNeil and Jimmy Wallace McNeil in his individual capacity as father of the decedent. Michael Jay McNeil is deceased and Jimmy Wallace McNeil does not appear in his individual capacity before this Court.

Defendant-appellee below, and respondent in this Court, is Time Insurance Company.

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner McNeil respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

Petitioner is the father and executor of the estate of decedent Dr. Michael Jay McNeil. In September 1994, Dr. McNeil was diagnosed with AIDS and was admitted to the hospital for treatment of pneumonia. Dr. McNeil died on March 1, 1995. Respondent Time Insurance Company (Time) was Dr. McNeil's health insurer. Time paid the first $10,000 of insurance claims submitted by Dr. McNeil but, based on a policy limit applicable to persons disabled with AIDS, denied coverage for over $400,000 of subsequent medical expenses. This petition involves whether such a

limitation violates the Americans with Disabilities Act (ADA) and whether state law barring such discrimination in insurance is preempted by ERISA.

OPINIONS BELOW

This case was originally brought in Texas state court alleging various state-law claims based on discrimination in the provision of insurance coverage. Respondent Time removed the case to federal court based on alleged ERISA preemption, the Complaint was amended thrice to include certain federal claims, and eventually the district court granted motions for summary judgment and dismissal in favor of Time.

The district court's decision granting Time summary judgment on McNeil's claim under Title III of the ADA is unpublished and is reproduced as Appendix B (pages B1-B8). The district court's denial of reconsideration of that decision is unpublished and is reproduced as Appendix C (pages C1-C2). The district court's decision granting Time summary judgment on several state-insurance-law claims is unpublished, though electronically available at 1997 WL 182274, and is reproduced as Appendix D (pages D1-D11). The district court's denial of reconsideration of that decision is unpublished, though electronically available at 1997 WL 340952, and is reproduced as Appendix E (pages E1-E3). The district court's decision finding all of McNeil's state-law claims preempted by ERISA is published at 977 F. Supp. 424 and is reproduced as Appendix F (pages F1-F13). The district court's order dismissing all of McNeil's claims except those brought under ERISA is unpublished and is reproduced as Appendix G (page G1). The district court's denial of reconsideration on the ERISA issues is unpublished and is reproduced as Appendix H (page H1). The district court's order granting Time summary judgment on state-law claims relating to the failure to follow sound actuarial principles is unpublished and is reproduced as Appendix *I* (page *I*1). The district court's order dismissing the remaining ERISA claims

and entering final judgment is unpublished and is reproduced as Appendix J (pages J1-J2).

The Fifth Circuit's decision affirming the district court is published at 205 F.3d 179 and is reproduced as Appendix A (pages A1-A21). The Fifth Circuit's denial of petitions for rehearing and rehearing *en banc* is unpublished and is reproduced as Appendix K (pages K1-K2).

JURISDICTION

The Fifth Circuit issued its decision in this case on February 24, 2000 and its order denying petitions for rehearing and rehearing *en banc* on June 28, 2000. On September 11, 2000, Justice Scalia extended the time for filing a petition for certiorari to and including November 27, 2000. This Court has jurisdiction to hear this petition pursuant to 28 U.S.C. § 1254(1)

STATUTORY PROVISIONS INVOLVED

Section 302(a) of Title III of the ADA, 42 U.S.C. § 12182(a), provides:

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

Section 501(c) of Title V of the ADA, 42 U.S.C. § 12201(c), provides, in relevant part:

> (c) Insurance
>
> Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict--
>
> (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or adminis-

tering such risks that are based on or not inconsistent with State law;

* * *

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter.

The preemption provision of ERISA, 29 U.S.C. § 1144, provides, in relevant part:

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

STATEMENT OF THE CASE[1]

Dr. McNeil was an optometrist residing and doing business in Texas. In 1994, he was half of a partnership known as Drs. Dickey & McNeil, Optometrists (the Partnership). The Partnership had only one employee – Ms. Jana Jay, the secretary. In April 1994, Dr. McNeil purchased and received from respondent Time a health insurance policy. The Partnership purchased from Time health insurance for its em-

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[1] Unless otherwise noted, the facts are taken from the Fifth Circuit and district court opinions, attached as Appendices A through J.

ployee, Ms. Jay. The premiums for Ms. Jay were paid for by the Partnership from Partnership funds, while Dr. McNeil paid the premiums for his own insurance from his personal funds. Dr. McNeil's policy provided lifetime maximum benefits of $2 million, contained no limitation on pre-existing conditions, but limited coverage for AIDS-related expenses to $10,000 during the first two years the policy was in effect. After two years the policy covered AIDS-related claims up to the full policy limit. Time's AIDS-based coverage limitation has no actuarial basis and was not based on any actual or anticipated experience.

In September 1994, Dr. McNeil was diagnosed with AIDS. Dr. McNeil was admitted to the hospital at that time, for treatment of pneumonia. Time paid the first $10,000 of insurance claims submitted by Dr. McNeil. After November 1994, however, Time denied all of Dr. McNeil's claims, asserting that the policy did not provide coverage beyond $10,000 for such claims. Over $400,000 of medical expenses for McNeil remain unpaid by Time.

Dr. McNeil died on March 1, 1995.

Before his death, Dr. McNeil sued Time in Texas state court for violations of various duties imposed by Texas law.[2] Time removed to federal court based on ERISA. Dr. McNeil's complaint was thereafter amended a number of times, ending with the Third Amended Complaint (hereinafter the Complaint). The Complaint challenged the AIDS-based limitation, claiming violations of various state-law duties governing the provision of insurance. In federal court, the Complaint also added claims for violation of the ADA and ERISA.

Through a series of decision, the district court granted summary judgment against or dismissed all of the claims in

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[2] After Dr. McNeil's death, the suit was continued by his father individually and as executor of Dr. McNeil's estate.

the Complaint. Regarding the ADA claim, the court held that Time's provision of insurance is not subject to Title III of the ADA. App. B4-B7. The court denied McNeil's motion for reconsideration. App. C2. Regarding certain state-law claims alleging violation of various insurance-specific duties, the court held that the AIDS based limitation was enforceable, App. D4-D10, and again denied McNeil's motion for reconsideration. App. E3.

Thereafter the court tried the sole issue of whether an ERISA plan existed and dismissed all remaining state-law claims as being preempted by ERISA. App. F13, G1. The court denied McNeil's motion for reconsideration or a new trial. App. H1. The district court also entered a separate order granting Time's motion to dismiss various state-law claims that were based on Time's failure to follow sound actuarial principles. App. *I*1. On April 23, 1998 the court entered final judgment dismissing the remaining ERISA claims. App. J1-J2.

McNeil appealed.

The Fifth Circuit affirmed. Regarding McNeil's ADA claim, the court held that Title III does not "regulate the content of goods and services that are offered." App. A11. The court claimed that the "goods and services that the business offers exist *a priori* and independently from any discrimination," App. A11-A12, and that the "good" in this case is the insurance policy that Time offered to the members of the Texas Optometric Association," App. A15. There was no ADA violation, the court argued, because

> Time offered the policy to [Dr. McNeil] on the same terms as it offered the policy to other members of the association; that is, [Dr. McNeil] had non-discriminatory access to the good. Mr. McNeil has not alleged that Time interfered with his son's ability to enjoy that policy as it was written and offered to the non- disabled public.

App. A15. The court concluded that "[b]ecause Title III does not reach so far as to regulate the content of goods and services, and because it is undisputed this limitation for AIDS is part of the content of the good that Time offered, Mr. McNeil's Title III claim must fail." App. A15-A16. The Fifth Circuit refused to consider the contrary administrative construction of Title III by the Department of Justice, App. A11 n.8, and failed even to mention the unambiguous legislative history demonstrating that Congress understood and intended Title III to cover the content of insurance policies and provided a limited safe-harbor to that coverage.[3]

Regarding various of the state-law claims, the Fifth Circuit held that they were preempted by ERISA. The court began by holding that the insurance policy constituted an ERISA plan notwithstanding that Dr. McNeil paid his own premiums for his insurance, App. A17, and notwithstanding that the Partnership did nothing to "administer" the supposed plan, but rather merely paid the insurance premiums for Ms. Jay, the secretary, App. A19. The court also rejected the argument that ERISA was inapplicable because the supposed plan had no connection to any interstate labor or employment. Without analyzing the language of ERISA, the court asserted that because the Partnership purchased some glasses from

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[3] The court also held, App. A5, A7-A8, that Time did not violate part of the state insurance code providing that an insurer "may not * * * limit the amount, extent, or kind of coverage available to an individual * * * solely because of handicap or partial handicap, except where * * * based on sound actuarial principles or [where] related to actual or reasonably anticipated experience." Tex. Ins. Code Ann. Art. 21.21-3. Despite the policy's denial of coverage for identical treatments of identical illnesses (such as pneumonia) based exclusively on whether the insured had AIDS, the court stated that Time "was merely applying a term of the policy" and not limiting coverage "because of" handicap. App. A8. This confusion derives from the same error applied to the ADA claim, is thus bound up in the federal error, and, along with other state-law errors, would need to be revisited (or referred to the state courts) on remand once the ADA and ERISA errors were corrected.

other states and because the insurer was from out of state, the supposed plan fell within ERISA's jurisdictional ambit. App. A19.

Having found an ERISA plan, the court then found preemption of McNeil's state claims because such claims related to the right to receive benefits under the supposed plan. App. A21. The court dismissed the argument that the preemption inquiry "has been fundamentally altered by the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 * * * (1995)," with the *non sequitur* that the "method of analysis we use today was well established before that decision, and it continues to be used today." App. A20 n.20 (comparing Fifth Circuit cases before and after *Travelers*). The court also rejected, without analysis, the argument that petitioner's state-law claims, based on duties created by Texas insurance law, were saved from preemption by ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), which provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." App. A21.

McNeil petitioned for rehearing and rehearing *en banc*. After three months, the Fifth Circuit denied those petitions without explanation. App. K1.

This petition for certiorari followed.

REASONS FOR GRANTING THE WRIT

Certiorari should be granted because the Fifth Circuit's holdings limiting the scope and protection of the ADA and expanding the scope and coverage of ERISA and ERISA preemption conflict with decisions from other circuits, conflict with decisions of this Court, and present important national issues that should be addressed by this Court.

I. THE FIFTH CIRCUIT'S RESTRICTIVE INTERPRETATION OF THE ADA CONFLICTS WITH THE DECISIONS OF OTHER COURTS AND IS WRONG.

Title III of the ADA states, in relevant part, that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. §12182(a). Under the plain language, administrative construction, and legislative history of the ADA, an insurance office is a place of public accommodation, insurance coverage is a good, service, privilege or advantage of that place of public accommodation, and persons may be denied the full and equal enjoyment of insurance coverage by terms in an insurance policy that, without any sound actuarial basis, expressly discriminate in the amount of coverage available based on whether the insured has a specified disability.

A. There Is a Circuit Split Regarding Title III's Application to Insurance.

The decision below that Title III does not apply to discriminatory policy terms restricting insurance coverage conflicts with *Pallozzi* v. *Allstate Life Ins. Co.*, 198 F.3d 28, 32 (CA2 2000) (as amended), where the Second Circuit held that the text of Title III makes it "clear" that it was "intended by Congress to apply to insurance underwriting." Indeed, the Fifth Circuit below expressly rejected the Second Circuit's holding in *Pallozzi*. App. A14-15 ("the Second Circuit read Title III to regulate content as well as access, a reading that we ultimately find unpersuasive").

While diverging from the Second Circuit, the court below reached the same result as the Third, Sixth, Seventh, and Ninth Circuits, each of which has refused to apply Title III to the substance of insurance policies. App. A14 & nn.12-13; see *Ford* v. *Schering-Plough Corp.*, 145 F.3d 601, 614 (CA3

1998) (insurance policy limiting coverage for mental disabilities did not violate Title III), *cert. denied*, 525 U.S. 1093 (1999); *Parker* v. *Metropolitan Life Ins. Co.*, 121 F.3d 106, 1012 (CA6 1997) (*en banc*) ("Title III does not govern the content of a LTD policy"), *cert. denied*, 522 U.S. 1084 (1998); *Doe* v. *Mutual of Omaha Ins. Co.*, 179 F.3d 557, 560 (CA7 1999) ("the content of goods or services offered by a place of public accommodation is not regulated"), *cert. denied*, 120 S. Ct. 845 (2000); *Weyer* v. *Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115 (CA9 2000) ("Title III does not address the terms of the policies that [a carrier] sells."); see also *Lenox v. Healthwise of Kentucky, Ltd.*, 149 F.3d 453, 457 (CA6 1998) (Title III does not reach disparities in health insurance coverage and requires only removal of physical barriers to access).

In addition to the conflict between the circuits, numerous district courts have taken sides in the split. See *Wai* v. *Allstate Ins. Co.*, 75 F. Supp.2d 1, 8 (D.D.C. 1999) ("Title III's protections extend beyond physical access to insurance offices"); *Boots* v. *Northwestern Mut. Life Ins. Co.*, 77 F. Supp.2d 211, 215-216 (D.N.H. 1999) (Title III regulates "substance of an insurance policy"); *Conners* v. *Maine Medical Center*, 42 F. Supp.2d 34, 46 (D.Me. 1999) ("under the plain language of Title III, the Act would extend to the substance or contents of an insurance policy"); *Doukas* v. *Metropolitan Life Ins. Co.*, 950 F. Supp. 422, 425 (D.N.H. 1996) ("plain language of Title III" covers the "substance or contents of an insurance policy"). Furthermore, even in some circuits reaching the same results as the decision below, previous – and better-reasoned – district court opinions in those circuits had agreed with petitioner's construction of Title III. See *Doe* v. *Mutual of Omaha Ins. Co.*, 999 F. Supp. 1188, 1194 (N.D.Ill. 1998) ("Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer."),

rev'd, 179 F.3d 557, 560 (CA7 1999), *cert. denied*, 120 S. Ct. 845 (2000); *Cloutier* v. *Prudential Ins. Co. of America*, 964 F. Supp. 299, 302 (N.D.Cal. 1997) ("where underwriting lacks such [an actuarial or state-law] basis, it fails to comply with the ADA"); *Attar* v. *Unum Life Ins. Co. of America*, 1998 WL 574885, *2 (N.D.Tex. 1998) ("It seems plain to this Court that the Plaintiffs' insurance policy is a 'service' of Defendants' 'insurance office,' and thus falls squarely within the purview of Title III. ... The statutory language draws no distinction between the content of a good, service, or privilege on the one hand, and access to a good, service, or privilege on the other."); *Chabner* v. *United of Omaha Life Ins. Co.*, 994 F. Supp. 1185, 1192 (N.D. Cal. 1998) ("the plain language of the statute supports a finding that insurance underwriting practices are covered by Title III"), *aff'd on other grounds, rev'd on issue in question*, 225 F.3d 1042 (CA9 2000).

This conflict among both the circuits and the district courts calls for resolution by this Court. The need for review in this case is magnified by the circumstance that the decision below is fundamentally wrong and thereby exempts from a federal remedial statute an entire class of public accommodations discriminating against the disabled in the provision of insurance coverage.

B. The Exclusion of Discriminatory Insurance Terms from Coverage under Title III Is Erroneous.

The fundamental conceptual error of the Fifth Circuit was in conflating the terms of an insurance policy with the good or service of insurance coverage. By treating the policy "as it was written" as the good or service in question, App. A15, the court mistakenly concluded that the disability-based limitation was somehow inherent to the good or service and thus could not be challenged without altering the good or service provided. The real issue here is what constitutes the baseline product. The court merely assumed that the good or service was whatever the insurance company said it was. But the

good or service in question is insurance coverage generally, and the only limitations inherent in that good are those that are supported by sound actuarial principles and state insurance law. The facile notion that *any* policy term becomes inherent to the good or service and thus cannot be discriminatory would justify all manner of discrimination so long as it was written into the policy. Of course, this Court under the Rehabilitation Act has rejected just such an approach to discrimination in the context of non-tangible goods or services. *Alexander* v. *Choate*, 469 U.S. 287, 289 (1985), addressed a benefit limitation and recognized just this type of discrimination, noting that anti-discrimination legislation "'can obviously be emptied of meaning if every discriminatory policy is "collapsed" into one's definition of what is the relevant benefit'" and that "[t]he benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled * * *." 469 U.S. at 301 n.21 (citation omitted). The Fifth Circuit decision thus effectively conflicts with this Court's precedent under the Rehabilitation Act.

The Fifth Circuit's logic would countenance a limitation on payments if the recipient is or becomes blind, deaf, or crippled, and would even lead to the conclusion that incorporated limitations on payments to blacks, Catholics, or Jews are merely part of the policy, and hence the "good," offered equally to everyone. But the notion that one can merely redefine a good or service in discriminatory terms failed in the civil rights context (serving meals could not be redefined as serving meals to whites only) and is equally bankrupt when disinterred in support of discrimination against the disabled.

Furthermore, the Fifth Circuit is mistaken in its claim that the ADA does not require alterations in the substance of goods, services, or benefits. A public accommodation *is required* to make reasonable modifications to policies, practices, or procedures, or take other steps to prevent differential treatment of the disabled, unless the entity can prove that such

changes would "fundamentally alter the nature" of the entity's goods, services, or privileges. 42 U.S.C. §12182 (b)(2)(A)(ii) & (iii). The court's claim that §12182(b)(2)(A)(ii) has "nothing to do with the content of a good or service, only to non-physical access to those goods and services," App. A11 n.9, ignores subsection (A)(iii), which refers to altering goods or services, but provides a defense to such alteration if it would be "fundamental."[4]

In addition to the core conceptual error of the decision below, the Fifth Circuit also erred in the basic nuts-and-bolts task of statutory construction. The plain language of Title III covers discrimination by an insurance company in the provision of insurance coverage. Insurance coverage is among the "goods, services, facilities, privileges, advantages, or accommodations of [a] place of public accommodation" of which the disabled are guaranteed "full and equal enjoyment." 42 U.S.C. §12182(a).

The applicability of this straightforward language to the substance of insurance is confirmed by § 501(c) of the ADA, 42 U.S.C. §12201(c), a "safe harbor" that provides, in relevant part, that the ADA "shall not be construed to prohibit or restrict-- (1) an insurer * * * from underwriting risks, classifying risks, or administering such risks *that are based on or not inconsistent with State law*." (Emphasis added.) Underwriting and classifying risks are activities involving the definition or content of the insurance policy itself. There is no point to such a safe harbor if the ADA does not otherwise apply to the terms and conditions of insurance contracts. Cf. *Astoria Fed. Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 112 (1991) ("we construe statutes, where possible, so as to avoid rendering superfluous any parts thereof").

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[4] In insurance, *fundamental* alteration of the product can only be measured according to sound actuarial principles. Where there is no actuarial basis for a restriction to begin with, the removal of that restriction would not be a "fundamental" alteration in the insurance product.

The Fifth Circuit argued that the "presence of this [safe harbor] provision merely suggests that insurers saw the potential for the construction that Mr. McNeil proposes and obtained special wording from Congress that partially exempted them." App. A12 n.10. The court also claimed that "it would be oxymoronic to interpret the 'safe harbor' for the insurance industry as ensuring more regulation of that same industry." *Id.* The only thing oxymoronic is the notion of a "partial[]" exemption from a problem that supposedly does not exist. The safe harbor does not result in greater regulation of insurance, it merely creates parity because all other public accommodations are required to make reasonable changes to their goods, services or benefits so long as those changes do not fundamentally alter those items. The safe harbor translates this basic ADA requirement into insurance language by defining fundamental alterations according to actuarial principles.

In addition to the plain language of the statute, both the administrative interpretation of Title III and the legislative history overwhelmingly confirm that discriminatory terms in insurance policies are subject to ADA scrutiny. See DOJ, Title III Technical Assistance Manual: Covering Public Accommodations and Commercial Facilities, §III-3.11000, at 19 (Nov.1993) ("Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts *or in the terms or conditions of the insurance contracts they offer.*") (emphasis added)[5]; 28 C.F.R. Part 36, App. B, at 601 (July 1, 1998 ed.) (ADA "reach[es] insurance practices by prohibiting differential treatment of individuals with disabilities in insurance

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[5] As this Court has recently reaffirmed, DOJ is "the agency directed by Congress to issue implementing regulations, *see* 42 U.S.C. §12186(b), to render technical assistance explaining the responsibilities of covered individuals and institutions, §12206(c), and to enforce Title III in court, §12188(b)." *Bragdon* v. *Abbott*, 524 U.S. 624, 646 (1998). As such, the "Department's views are entitled to deference." *Id.*

offered by public accommodations unless the differences are justified"); H.R.Rep. No. 485(II), 101st Cong., 2d Sess., at 137 reprinted in 1990 U.S.C.C.A.N. 267, 419 ("Under the ADA, a person with a disability cannot be denied insurance *or be subject to different terms or conditions of insurance based on disability alone*, if the disability does not pose increased risks.") (emphasis added).

Time's AIDS-based limitation plainly discriminates. That Time gave non-disabled persons the same policy incorporating the AIDS limitation proves only that its discrimination was fully institutionalized. *See Alexander*, 469 U.S. at 301 n.21. An insured without AIDS would receive $2 million coverage for pneumonia or brain cancer. Dr. McNeil was limited to $10,000 in coverage for the identical conditions and treatments. Dr. McNeil was not denied coverage *for* AIDS; he was denied otherwise-available coverage *because he had AIDS*. That is discrimination, and it is forbidden by the ADA.

Because the decision below conflicts with a decision of the Second Circuit and with the decisions of numerous district courts, and because the decision below is riddled with error, this Court should grant the petition for certiorari.

II. THE DECISION BELOW CONFLICTS WITH DECISIONS FROM THIS COURT AND NUMEROUS OTHER COURTS RECOGNIZING THE MUCH-NARROWED SCOPE OF ERISA PREEMPTION.

In a misapprehension of recent developments in ERISA law, the Fifth Circuit rejected the notion that ERISA preemption analysis "has been fundamentally altered by the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 * * * (1995)." App. A20 n.20. It instead compared its own cases before and after *Travelers* and held that "method of analysis we use today was well established before that decision, and it continues to be used today." App. A20 n.20. But that fact that the Fifth Circuit has frequently fallen into error

does not validate its earlier misreading of the law, and in fact highlights the need for this Court to step in.

Whether state law "relate[s] to" an ERISA plan requires an extensive inquiry into both the nature of the law and the purposes of ERISA. The panel did none of that, but instead relied upon a simplistic and overbroad preemption formulation from a bygone era. In *Travelers*, this Court reversed a long trend of expansive ERISA preemption, and reemphasized the "starting presumption that Congress does not intend to supplant state law. * * * [W]e have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress. 514 U.S. at 654-55 (citations and quotation marks omitted).

The conclusion that *Travelers* changed nothing is wrong and conflicts with numerous decisions from this Court and from other circuits now reading ERISA preemption narrowly. *See, e.g., De Buono* v. *NYSA-ILA Medical and Clinical Servs. Fund*, 520 U.S. 806, 812-16 (1997) (rejecting court of appeals' "expansive and literal interpretation" and criticizing court for its "failing to give proper weight to *Travelers'* rejection of a strictly literal reading of" the ERISA preemption language); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction, N.A., Inc.*, 519 U.S. 316, 325 (1997) (noting *Travelers'* rejection of "uncritical literalism" in interpreting the ERISA preemption language); *Abdu-Brisson* v. *Delta Air Lines, Inc.*, 128 F.3d 77, 82 (CA2 1997) ("The Supreme Court in addressing the preemption provisions of ERISA has been limiting preemption's reach."); *Coyne & Delany Co.* v. *Selman*, 98 F.3d 1457, 1466 (CA4 1996) (describing the "recent (and narrowing) interpretation of the scope of ERISA preemption in" *Travelers*); *Morstein* v. *National Ins. Servs., Inc.*, 93 F.3d 715, 721 (CA11 1996) (*en banc*) (characterizing *Travelers* as having "essentially turned the tide on the expansion of the preemption doctrine"), *cert. denied sub nom. Shaw Agency* v. *Morstein*, 519 U.S. 1092

(1997); *Egelhoff* v. *Egelhoff*, 989 P.2d 80, 86, 87 (Wash. 1999) (*en banc*) ("Recently, however, ERISA preemption analysis by the United States Supreme Court, as evidenced by [*Travelers*] has signaled a significant retreat from its expansive reading of § 1144(a)."; "effect of *Travelers* and its progeny favors a retreat from the expansive preemption doctrine this Court has previously followed"), *cert. granted*, 120 S. Ct. 2687 (2000) (No. 99-1529).

At a minimum, *Travelers* and its progeny set up a methodology for evaluating the preemptive effect of ERISA – a methodology that the panel inexplicably ignored. Each of the *Travelers* factors demonstrates that none of the state law relied upon by McNeil "relates" to an ERISA plan in the specific way that statutory term is now interpreted.

The laws invoked by McNeil go to the substance of insurance generally – whether or not purchased by an ERISA plan – and not to the procedures, administration, funding or anything else covered by ERISA. Here, Texas simply removed a particular health-care product – unfairly discriminatory insurance policies – from the market, making them unavailable for purchase by an ERISA plan or anybody else. That is no different than numerous other State actions restricting the products and services – marijuana or prostitution, for example – available for purchase regardless of whether an ERISA plan might wish to include such "benefits." Such health-care legislation was not meant to be preempted by ERISA. See *Boyle* v. *Anderson*, 68 F.3d 1093, 1109 (CA8 1995) ("*Travelers* and the other precedents cited in this litigation compel this court not to preempt a state's effort to serve as a 'laboratory of democracy' in the realm of health care."), *cert. denied*, 516 U.S. 1173 (1996).

In every way that counts, this case is like *Travelers*. Texas law "does not bind ERISA plans to anything," *Dillingham*, 519 U.S. at 332, as such plans are not obliged to provide their benefits through the purchase of insurance, but may do so "otherwise," 42 U.S.C. §1002(1). Insurance is not the

"plan" itself, but merely *one means* of providing the benefits under a plan. *See* 29 U.S.C. §1002(1). An ERISA plan thus may exclude whatever coverage it likes by self-insuring. The effect of that choice "is merely to provide some measure of economic incentive" to choose the non-discriminatory insurance option, *Dillingham*, 519 U.S. at 332.

The Fifth Circuit's error in preemption analysis is compounded by three related further errors. First, ERISA does not preempt state laws that "regulate[] insurance," and thus satisfy ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), even when such laws "relate to" an ERISA plan. The court offered only the unadorned conclusion that "none of the remaining state law claims satisfies these requirements. Thus, these state laws do not fall within the savings clause." App. A21. That conclusion was wrong and conflicts with *Unum Life Insurance Co. of America* v. *Ward*, 526 U.S. 358 (1999).

In *Unum*, this Court applied a more inclusive, "commonsense" approach to whether a law regulates insurance, and specifically rejected the more restrictive assertion that a law "must satisfy all three McCarran-Ferguson factors in order to 'regulate insurance.'" 526 U.S. at 373. The Court found that a rule met the common sense test if it "is directed specifically at the insurance industry and is applicable only to insurance contracts." *Id.* at 368. The Court then proceeded to hold that a court-made notice-prejudice rule applicable to insurance contracts came within the savings clause despite its similarity to general common-law contract rules requiring prejudice before imposing forfeiture. The "notice- prejudice rule is distinctive most notably because it is a rule firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters." 526 U.S. at 371. The approach and conclusion in *Unum* constitute an emphatic statement that ERISA's savings clause is more toothsome than some lower courts had previously held.

In this case, the *Unum* approach confirms that the state insurance code provisions and insurance-specific common-law doctrines are saved from preemption. That such law may bear some similarity to more general common-law principles is irrelevant because in Texas there are special and more stringent rules for insurance contracts and under insurance statutes that qualify as law regulating insurance. The myriad insurance code provisions self-evidently regulate insurance, and McNeil's various common-law claims go to the substantive terms of the insurance contract and are all based on duties created by insurance code provisions and insurance-specific cases. As this Court has held, "regulation regarding the substantive terms of insurance contracts falls squarely within the savings clause as laws 'which regulate insurance.'" *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 742-43 (1985); see also *Pilot Life Ins. Co.* v. *Dedeaux,* 481 U.S. 41, 48 n.1 (1987) ("Decisional law that 'regulates insurance' may fall under the saving clause."); *Hansen* v. *Continental Ins. Co.,* 940 F.2d 971, 982 (CA5 1991) ("In contracts of insurance generally, ambiguities are resolved against the drafter."); *Howard* v. *INA County Mut. Ins. Co.,* 933 S.W.2d 212, 219 (Tex.App.—Dallas 1996) ("Statutes bearing ... defining the rights and liabilities of parties to insurance contracts become a part of the contract."). Each of the laws relied upon by McNeil "focuses on the insurance industry," 526 U.S. at 375 n.5, and each is saved.

Second, the Fifth Circuit essentially ignored the underlying purposes of ERISA and extended its jurisdictional reach to supposed "plans" having nothing to do with interstate labor markets or interstate employers. Not all entities that purchase insurance have a sufficient nexus to interstate commerce to fall under ERISA. *Meredith* v. *Time Ins. Co.*, 980 F.2d 352, 354 n.8 (CA5 1993). It is undisputed that the Partnership did not treat patients from out of state. The only connection to commerce was the Partnership's purchase of some glasses that came from out of state. That bare connection is insuffi-

cient to trigger ERISA. It is one thing to say that such sales could support specific jurisdiction over the sale of the glasses themselves, but it is too great a stretch to suggest such limited sales create general federal jurisdiction over everything done by the Partnership. ERISA coverage "is defined by the labor component of the business rather than its use of the instrumentalities of interstate commerce * * * or other criteria of interstate effect." *Sheffield* v. *Allstate Life Ins. Co.*, 756 F. Supp. 309, 310 (S.D.Tex. 1991).

The Partnership had only a single employee in Texas, and the Partnership's labor relations could have had no conceivable relation to interstate commerce. "ERISA addresses those employers whose labor disputes could affect interstate commerce." *Id.* And as for McNeil, it is simply silly to suggest that *he* could have a labor dispute with himself over the insurance he purchased for himself. As to anything involving McNeil's insurance, there is not even a scintilla of ERISA-relevant connection to commerce. This Court's recent precedents suggest that where there is doubt about the *relevant* commerce connection of an activity, a statute's jurisdictional reach should be read narrowly so as not to press the bounds of congressional power. See *Jones* v. *United States*, 529 U.S. 848 (2000) (narrowly construing reach of federal arson statute).

A narrow construction of ERISA's jurisdictional language makes ample sense in this case and fits hand-in-glove with the narrowing scope of ERISA preemption. If the mere purchase of some goods from out of state unbridled commerce authority over all aspects of a business, then nobody is immune: all businesses buy something – paper clips, toilet paper, or light bulbs – from out of state. The commerce power "may not be extended so as to embrace effects upon interstate commerce so indirect and remote." *NLRB* v. *Jones & Laughlin Steel Corp.*, 301 U.S. 1, 37 (1937); see *United States* v. *Lopez*, 514 U.S. 549, 567 (1995) (declining "to pile inference upon inference in a manner that would bid fair to convert congressional

authority under the Commerce Clause to a general police power of the sort retained by the States"). The Partnership's purchase of a minor quantity of glasses made outside of Texas lacks a "labor" connection and does not create federal authority under the commerce clause and ERISA.

Third, the Fifth Circuit employed an overly broad definition of an ERISA plan, and consequently extended ERISA coverage, and ERISA preemption, into areas in which it makes no sense. Thus, in this case, regardless of what the Partnership may have done for Ms. Jay, Dr. McNeil paid for his own insurance and was dealing with an insurance company selling policies otherwise subject to state insurance regulation, not an employee benefit administrator or anyone else that ERISA might wish to regulate. There is no administration of a fund, no interstate conflict to be avoided, and nothing at all different from the relationship between any individual insured and an insurance company. And even looking to the Partnership's relationship with its sole employee, beyond purchasing Ms. Jay's insurance, the Partnership did *nothing* that might establish an ERISA plan. It did not hire an administrator, it did not engage in any administrative activity itself, and it did not take any steps required under ERISA. To find that the Partnership administered a plan even as to Ms. Jay requires far more. *See generally, Fort Halifax Packing Co.* v. *Coyne,* 482 U.S. 1, 6-13 (1987) (discussing complexities of ongoing administrative activities that were the concern of ERISA, and distinguishing ministerial activity such as writing a check).

These three compounding errors affect the preemption issue by expanding potential ERISA preemption into areas in which it makes no sense, by causing ERISA to displace far more state law than Congress likely intended, and by minimizing the degree of federal interest at stake under the *Travelers* analysis. While each error standing alone is enough to warrant reversal, the combined effect of these errors, and their effect going forward, stand in serious conflict with this

Court's recent determinations that ERISA preemption had gotten out of hand and needed to be reigned in.

III. This Case Raises Important National Issues that Should Be Resolved by this Court.

The ADA and ERISA questions presented by this case are important national issues in that they affect vast quantities of people who purchase insurance and who have one or another form of disability. The Fifth Circuit's decision in this case affects huge population centers in Texas and Louisiana. The Third, Sixth, Seventh, and Ninth Circuits likewise cover a tremendous portion of this nation's population. Those circuits are in conflict with the approach in the Second Circuit, which likewise covers a tremendous population center as well as one of the Nation's major insurance centers (Hartford, Connecticut). The inconsistent application of the ADA between such large portions of the population calls for this Court's intervention to provide a unifying answer.

Similarly, the Fifth Circuit's apparent refusal to come in line with this Court's narrowed approach to ERISA preemption places it at odds with numerous other circuits who have recognized the change, and is an affront to the states and the state laws within the Fifth Circuit. As this Court has recognized so many times in the past, ERISA preemption is a recurring and problematic issue that warrants this Court's attention. Because the Fifth Circuit shows no sign of acknowledging the new methodology to such preemption, this Court should step in. At a minimum, this Court should hold the case pending its decision in *Egelhoff*, No. 99-1529, and then either grant, vacate, and remand in light of that case, or grant plenary review to so as to finally and definitively clarify the issue in the Fifth Circuit.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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Dated: November 27, 2000.

APPENDICES

APPENDIX A

205 F.3d 179

**United States Court of Appeals,
Fifth Circuit.**

**Michael Jay McNEIL, et al., Plaintiffs,
Jimmy Wallace McNeil, as Independent Executor and Representative of the Estate of Michael Jay McNeil, Plaintiff-Appellant,
v.
TIME INSURANCE COMPANY, Defendant-Appellee.**

**No. 98-10585.
Feb. 24, 2000.**

Cynthia Anne Leiferman (argued), Austin, TX, Erik Scott Jaffe, Washington, DC, for Plaintiff-Appellant.

Andrew George Jubinsky, Timothy A. Daniels (argued), Figari & Davenport, Dallas, TX, for Defendant-Appellee.

Ronald Lawrence Wilson, New Orleans, LA, for American Civil Liberties Union Foundation, Amicus Curiae.

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Gregory Bryan Friel, Jessica Dunsay Silver, U.S. Department of Justice, Civil Rights Division, Appellate Section, Washington, DC, for United States of America, Amicus Curiae.

Stephanie W. Kanwit, Epstein, Becker & Green, Washington, DC, for Health Insurance Association of America and American Council of Life Insurance, Amici Curiae.

Appeal from the United States District Court for the Northern District of Texas.

Before REYNALDO G. GARZA, JOLLY and DeMOSS, Circuit Judges.

E. GRADY JOLLY, Circuit Judge:

In this case, we are presented difficult questions of statutory interpretation that determine whether the defendant insurance company is liable for more than $400,000 in hospital bills, which the insured, now deceased, incurred as a result of his losing battle with AIDS. In addition to state statutory questions, we must decide whether the Americans with Disabilities Act's ("ADA") anti-discrimination provisions regulate the terms and content of an insurance policy. We ultimately decide that the ADA does not regulate the terms or content of goods and services, of which this insurance policy is one. We therefore affirm the district court's grant of summary judgment dismissing the complaint.

I

In the spring of 1994, Dr. Michael McNeil, a Texas optometrist, did not know that he would be dead within the year because of AIDS. He thus routinely sought to cover himself and his employee in his optometry practice under a general health insurance plan.

Dr. McNeil's optometry practice was a two-person partnership with Dr. Roy F. Dickey. The partnership had one employee, its secretary, Jana Jay. The partnership was a member of the Texas Optometric Association, which operated as a trust, allowing its members to purchase group insurance. In April, Dr. McNeil received information about a new life and health insurance policy offered by Time Insurance Company through the association. The brochure described the policy's benefits and costs. The policy contained no limitation on pre-existing conditions and provided lifetime maximum benefits of $2 million. There were limitations on coverage for several specific health problems. One of these was for

Acquired Immune Deficiency Syndrome ("AIDS"). The policy limited coverage for AIDS and AIDS Related Complex ("ARC") to $10,000 during the first two years of the policy but provided maximum benefits after that.

Dr. McNeil decided that the partnership should purchase this plan. He filled out the employer application, signing a document indicating that he had "authority to bind the employer," and then he and Ms. Jay mailed employee enrollment forms to Time. His form listed him as an "employee." Dr. Dickey was covered by Medicare and did not enroll. The partnership paid the first premium to Time for Dr. McNeil and Ms. Jay from its operating account, though Dr. McNeil later reimbursed the partnership for his portion. The plan became effective on May 1, 1994.

After the plan became effective, Dr. McNeil paid his own premiums, while the partnership paid for Ms. Jay's. During the plan's operation, the partnership's administrative duties consisted of receiving premium notices and paying Ms. Jay's premiums.

In September 1994, Dr. McNeil was diagnosed with AIDS. He was admitted to the hospital and treated for pneumonia. Time paid the first $10,000 of his costs but nothing more. Dr. McNeil subsequently incurred over $400,000 in medical expenses. He died on March 1, 1995.

Before his death, Dr. McNeil brought suit in Texas state court. After Dr. McNeil's death, his father and the executor of his estate took over the suit. Time later removed the case to federal court based on ERISA preemption and diversity. Mr. McNeil then amended the complaint several times. The last version, the Third Amended Complaint, asserted several common law causes of action: breach of contract, breach of the duty of good faith and fair dealing, negligent misrepresentation, common law discrimination, waiver, estoppel, and ratification. This amended complaint also charged that Time had violated a host of state and federal statutes, including the

Texas Deceptive Trade Practices Act ("DTPA"), the Texas Insurance Code, the Texas Commission on Human Rights Act ("TCHRA"), the Americans with Disabilities Act ("ADA"), and ERISA.

Mr. McNeil did not have much success in federal district court. First, the court dismissed the claims that were based on alleged violation of Texas insurance law. Second, the court held that Time's provision of insurance did not constitute a "public accommodation" under the ADA, and that Title III of that Act only applied to physical use of the services of a place of public accommodation. Since Mr. McNeil could point to nothing that prevented his son from making physical use of Time's services, the court dismissed the ADA claim. Third, the court held that ERISA preempted the remaining state law claims. Mr. McNeil now appeals each of these three determinations.

II

A

We first address the district court's dismissal of Mr. McNeil's claim under Article 21.21-3 of the Texas Insurance Code:[1]

> Art. 21.21-3. Discrimination Against Handicapped Prohibited

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[1] This provision was repealed in 1993 and was replaced by Tex. Ins. Code Ann. art. 21.21-6 (Vernon Supp.1977). When enacting Article 21.21-6, the Texas legislature provided that "[t]his Act takes effect September 1, 1995, and applies only to an insurance policy or an evidence of coverage that is delivered, issued for delivery, or renewed on or after January 1, 1996. A policy or evidence of coverage that is delivered, issued for delivery, or renewed before January 1, 1996 is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose." *Id.* (Historical and Statutory Notes). Because Dr. McNeil obtained his coverage before January 1, 1996, Article 21.21-3 provides the basis for his claim. We also note that because the district court dismissed this particular cause of action, it did not rule on whether ERISA preempted this claim. Our subsequent discussion of ERISA preemption, therefore, does not involve Article 21.21-3.

> An insurer who delivers or issues for delivery or renews any insurance in this state may not refuse to insure, refuse to continue to insure, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of handicap or partial handicap, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(Emphasis added). The district court first concluded that AIDS was not a "handicap" for purposes of this statute. The court acknowledged that although the statute did not define "handicap," the Texas Commission on Human Rights Act ("TCHRA") did,[2] and the two statutes were similar enough to warrant reliance on the TCHRA's definition. The district court then cited our holding in *Hilton* v. *Southwestern Bell Telephone Co.*, 936 F.2d 823, 828 (5th Cir. 1991), for the proposition that AIDS was not a handicap under the TCHRA and thus not a handicap under Article 21.21-3. The court went on to explain that Time's actions did not constitute "discrimination" under Article 21.21- 3 because Time inserted the AIDS limitation in all its policies regardless of whether the insured had AIDS. For these reasons, the district court dismissed this portion of Mr. McNeil's complaint for failure to state a claim.

Our analysis of this Texas law begins with statutory construction, a process we approach as a Texas court would. *General Electric Capital Corp.* v. *Southeastern Health Care, Inc.*, 950 F.2d 944, 950 (5th Cir. 1991). In Texas, the cardinal rule of statutory construction is to ascertain the "legislature's intent," and to give effect to that intent. *Union Bankers*

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[2] See Tex. Rev. Civ. Stat. Ann. art. 5221k § 2.01(7)(B) (Vernon 1987) (repealed 1993)(defining "handicap" as "a condition either mental or physical that includes mental retardation, hardness of hearing, deafness, speech impairment, visual handicap, being crippled, or any other health impairment that requires special ambulatory devices or services.").

Ins. Co. v. *Shelton*, 889 S.W.2d 278, 280 (Tex.1994). The duty of the court is to construe a statute as written and ascertain the legislature's intent from the language of the act. *Morrison* v. *Chan*, 699 S.W.2d 205, 208 (Tex.1985).

In condensed form and for purposes of the case before us, we read this statute as follows: An insurer who issues a policy may not limit the amount or extent of coverage to an individual solely because of handicap.[3] This reading leaves us with these questions. First, is AIDS a handicap for purposes of this statute, and, second, if AIDS is a handicap, did Time, the insurer, limit the amount or extent of the policy's coverage to the individual, Dr. McNeil, because of handicap?

We touch on the first question only briefly because the lack of clarity in Texas law makes us reluctant to say whether AIDS constitutes a handicap under the law of that state. The statute itself does not define the term "handicap," and there are no Texas administrative regulations we comfortably can rely on. We do note that the district court's analysis is not irrefutable. If we are to read and consider various statutes of a common purpose together, *Calvert* v. *Fort Worth National Bank*, 163 Tex. 405, 356 S.W.2d 918, 921 (1962); *Cadle Co.* v. *Butler*, 951 S.W.2d 901, 907 (Tex. App. 1997), we cannot stop, as the district court did, with the TCHRA. Administrative regulations interpreting Articles 21.20 and 21.21 do suggest that AIDS is a handicap and must also be considered.[4] For the sake of this appeal only, however, we will assume that AIDS is a handicap for purposes of Article 21.21-3.

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[3] We have omitted the possible defense, an actuarial basis or past experience, from this reformulation of the provision because Time has apparently conceded that it has no such defense in this case.

[4] The Texas Board of Insurance promulgated these regulations pursuant to Article 21.21 § 13(a). But the applicability of the Board's regulations was statutorily limited to interpretations of Articles 21.20 and 21.21, which are different articles than Article 21.21-3. See Tex. Rev. Civ. Stat. Ann. art. 2226 (treating 21.21 and 21.21-2 as separate articles); *Vail* v. *Texas Farm Bureau Mutual Ins. Co.*, 754 S.W.2d 129, 134 (Tex.1988) (same).

Even so, Time did not violate Article 21.21-3, either at the time that it issued the policy or when it refused to pay more than $10,000 in health care costs.

We begin with the issuance of the policy to Dr. McNeil. It is true that the policy limited its coverage for AIDS to $10,000 during the first two years of the policy. The statute, however, focuses on the conduct of the insurer. The phrase "because of handicap" indicates that the insurer must know that the applicant is handicapped and that the insurer limits coverage to that individual for that reason.[5] Dr. McNeil was not handicapped when Time issued this policy to him, or, at the least, Time did not know that he was. Thus, the limitation by the insurer could not have been "because of handicap."

But even if Time had known this when it sold Dr. McNeil the policy, we do not believe it would change our result. The statute specifies that the insurer may not limit the amount or extent of coverage available "to an individual." In short, the statute prevents an insurer from discriminating against an individual applicant because of handicap. Time offered this general policy without distinguishing between individual applicants based on whether they had AIDS. As long as Time offered Dr. McNeil the same policy it offered everyone else, Time has not violated Article 21.21-3, even assuming it knew that he had AIDS.

After Dr. McNeil was diagnosed with AIDS, Time refused to pay for anything above the $10,000 limit. But this

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[5] We cannot read "limit the amount or extent of coverage because of handicap" as "limit the amount or extent of coverage for handicap." First, "because of" and "for" clearly have different meanings. Second, that interpretation would raise vexatious questions for courts whenever they faced any limitation in a policy. Such a construction would require insurers to have an actuarial basis or past experience in support of every limitation on coverage for anything that could be construed as a handicap. Had the legislature intended such a drastic change in the legal requirements on the way insurers do business, we assume that it would have made that intent clearer.

refusal does not mean that the insurer limited the amount of coverage available solely because of handicap. Under the policy, $10,000 was all that was available for AIDS; the insurer simply applied the terms of the policy. The insurance policy itself controlled and determined the benefits.[6] But under the plain language of the statute, the violation must be committed by the insurer, not by a term of the policy. We thus conclude that Time did not violate Article 21.21-3, that is, limit the amount of coverage solely because of handicap, because it was merely applying a term of the policy.

We think this result, closely tied as it is to the actual words in Article 21.21-3, best accords with the legislature's intent. The title of Article 21.21-3 refers to "discrimination." But there was no discrimination here. Time offered Dr. McNeil the same policy on the same terms that it offered everyone else. It did not treat him differently because he was handicapped, which is what we understand "discrimination" to mean. We conclude, therefore, that Time's policy did not violate Article 21.21-3.

B

Mr. McNeil also charged Time with violation of Article 21.21, specifically, § 4(7)(b), in his summary judgment motion. Although the district court failed to address this claim, we will resolve it on appeal for the sake of efficiency, rather

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[6] This policy specified:

> Covered Charges Incurred for treatment of AIDS, AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV) associated diseases and related immunodeficiency disorders as follows:
>
> a. Benefits will not be paid for Covered Charges Incurred during the first 12-month period after the Covered Person's Effective Date;
>
> b. The maximum amount We will pay for Covered Charges Incurred during the second 12-month period after the Covered Person's Effective Date is limited to $10,000; and
>
> c. Thereafter, benefits will be paid on the same basis as any other illness.

than remanding. See *NL Industries, Inc.* v. *GHR Energy Corp.*, 940 F.2d 957, 967 (5th Cir. 1991) (reviewing claim not addressed in district court because it would "undoubtedly reappear following remand").

It is quickly apparent that Mr. McNeil does not have a claim under this provision either. Article 21.21 § 1(a) prohibits all unfair and deceptive practices and acts by insurers. Subsequent sections of that article then define what constitutes such an act or practice. In 1994, Article 21.21 § 4(7)(b)[7] defined "unfair discrimination" as:

> Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(Emphasis added). Mr. McNeil does not attempt to define the class to which his son belonged at the time the insurer issued the policy. He has not alleged that other individuals of any defined class were charged rates or provided benefits different from those charged and provided to Dr. McNeil. Indeed, he does not even mention other insureds or potential insureds. Thus, Mr. McNeil has failed to state a claim under this section of Article 21.21.

III

A

We next turn to Mr. McNeil's claim that Time's policy violated Title III of the ADA. The relevant portion of Title III reads:

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the

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[7] This provision was repealed in 1995. See Acts 1995, 74th Leg., ch. 414 § 11, eff. Sept. 1, 1995.

> goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

42 U.S.C. § 12182. The district court construed this statute to prohibit limitations on physical access to places of public accommodation, and dismissed the claim on summary judgment because Mr. McNeil had not been denied physical access to such a place.

On appeal, Mr. McNeil argues that any limitation on enjoyment of the goods and services of a place of public accommodation violates the statute. He urges us to read the statute expansively in the light of the purpose of the statute and administrative regulations interpreting it. Time, on the other hand, pushes for a narrower reading based on Congress' deference to state insurance law and on the impact of a broad reading on the insurance industry. Specifically, Time proposes that the statute merely regulates access to – not the content of – goods and services. Time also argues that its policy is not discriminatory under the statute. Both parties acknowledge, as they must, that AIDS is a "handicap" for Title III purposes. See *Bragdon* v. *Abbott*, 524 U.S. 624, 118 S. Ct. 2196, 2204, 141 L. Ed.2d 540 (1998).

B

We read the statute to say: No owner, operator, lessee, or lessor of a place of public accommodation shall discriminate against an individual by denying him or her, because of handicap, the full and equal enjoyment of the goods and services that the place of public accommodation offers. We think, therefore, that the question to answer in determining the scope of Title III in this case is concise: What does it mean to be discriminated against in the full and equal enjoyment of the goods and services of a place of public accommodation? We believe that Title III prohibits the owner, operator, lessee, or lessor from denying the disabled access to,

or interfering with their enjoyment of, the goods and services of a place of public accommodation. Title III does not, however, regulate the content of goods and services that are offered. We reach this conclusion based on the language in the statute and on a practical application of that language.[8]

To be sure, we think that the plain language of the statute demonstrates that a business is not required to alter or modify the goods or services it offers to satisfy Title III.[9] The prohibition of the statute is directed against owners, etc., of places of public accommodation. It prohibits them from discriminating against the disabled. The discrimination prohibited is that the owner, etc., may not deny the disabled the full and equal enjoyment of the business's goods and services. Practically speaking, how can an owner, etc., deny the full and equal enjoyment of the goods or services that he offers? By denying access to, or otherwise interfering with, the use of the goods or services that the business offers. The goods and

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[8] Because we reach our conclusion based on the plain language of the statute, we need not consider the administrative regulations interpreting the ADA. Any attempt to rely on those regulations, moreover, would be fruitless because they are internally contradictory on this specific issue. Compare DOJ Technical Assistance Manual, § III-3.11000, reprinted in Americans with Disabilities Act Manual (BNA) at 90:0917 (interpreting Title III to regulate the content of insurance policies); with 28 C.F.R. pt. 36, app. B, at 640 (1997)(limiting Title III to access, not the makeup of goods and services offered).

[9] Mr. McNeil contends that our reading renders other portions of Title III superfluous, including §§ 12182(b)(1)(A)(i)-(iii), 12182(b) (2)(A)(ii), and 12188(a)(2). We disagree. The provisions in §§ 12182(b)(1)(A)(i)-(iii) concerning the opportunity to benefit from or to participate in a good or service do not imply that the goods or services must be modified to ensure that opportunity or benefit. Rather, this section only refers to impediments that stand in the way of a person's ability to enjoy that good or service in the form that the establishment normally provides it. Similarly, in § 12182(b)(2)(A)(ii), eligibility criteria have nothing to do with the content of a good or service, only to non-physical access to those goods and services. Finally, § 12188(a)(2) concerns modification of policies by a place of public accommodation, not the modification of insurance policies.

services that the business offers exist a priori and independently from any discrimination. Stated differently, the goods and services referred to in the statute are simply those that the business normally offers.[10]

We acknowledge that it is literally possible, though strained, to construe "full and equal enjoyment" to suggest that the disabled must be able to enjoy every good and service offered to the same and identical extent as those who are not disabled. Construed in this manner, the statute would regulate the content and type of goods and services. That would be necessary to ensure that the disabled's enjoyment of goods and services offered by the place of public accommodation would be no less than, or different from, that of the non- disabled. But such a reading is plainly unrealistic, and surely unintended, because it makes an unattainable demand.

The unvarnished and sober truth is that in many, if not most, cases, the disabled simply will not have the capacity or ability to enjoy the goods and services of an establishment "fully" and "equally" compared to the non- disabled. The blind may surely enjoy attending a movie or even a tennis match. But it seems indisputable that the blind will not fully

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[10] Mr. McNeil has argued that Title III regulates the content of goods and services based on the safe harbor provision for the insurance industry. See 42 U.S.C. § 12201(c). That provision prohibits us from construing Title III to regulate the way insurance companies underwrite, classify, or administer risks when the companies do so consistently with state law. According to Mr. McNeil, this provision that excludes regulation of the content of such policies demonstrates that Title III otherwise applies to the content of insurance policies. We cannot agree, however, that the existence of the "safe harbor" counsels a construction different from the one we reach. We would then have to read Title III as regulating the content of all goods and services, which would lead to the absurd results that we discuss in the main body of our decision. The presence of this provision merely suggests that insurers saw the potential for the construction that Mr. McNeil proposes and obtained special wording from Congress that partially exempted them. Moreover, it would be oxymoronic to interpret the "safe harbor" for the insurance industry as ensuring more regulation of that same industry.

and equally enjoy the "good" or "service" of those places of public accommodation when visual elements of that experience are, by circumstance, denied them. Similarly, the deaf sometimes enjoy symphonies because they can sense the vibrations of the music. But their enjoyment cannot be full or equal compared to one with hearing, because they are not privy to the full range of sounds that one with hearing is. It is a flawed and unreasonable construction of any statute to read it in a manner that demands the impossible.

Furthermore, were we to try to construe the statute in this manner, its application would force impracticable results. If the blind must be able to enjoy all goods and services to the same extent as the sighted, bookstores would be forced to limit the selection of books they carried because they would need to stock braille versions of every book. Shoe stores would reduce the styles available to their general customers, because they would need to offer special shoes for people with disabling foot deformities in every style sold to the non-disabled. Sporting goods stores might have to close altogether. Restaurants would have to limit their menus to avoid discriminating against diabetics. After all, to offer food to the public that a diabetic could not eat would, in the literal words of the statute, deny the diabetic the full and equal enjoyment of the goods of the restaurant compared to those with no limitation on their diets.

By citing such examples, we do not mean to make the statute sound ridiculous. We do this to illustrate that the language of the statute can only reasonably be interpreted to have some practical, common sense boundaries. And if we construe Title III to regulate the content of goods and services, there seem to be no statutory boundaries. Based on the language of the statute, we simply see no non-arbitrary way to distinguish regulating the content of some goods from regulating the content of all goods.

In sum, we read Title III to prohibit an owner, etc., of a place of public accommodation from denying the disabled

access to the good or service and from interfering with the disableds' full and equal enjoyment of the goods and services offered. But the owner, etc., need not modify or alter the goods and services that it offers in order to avoid violating Title III.

We believe our construction gives Title III a broad sweep without overreaching congressional intent and with due regard to the practicalities of applying this mutable statute.[11] This construction assures that the disabled have access to all goods and services offered by the business and the opportunity to use and enjoy that good or service without interference by the owner, etc. Our opinion merely declines to dictate to every business in the country what types of goods and services must be offered.

We note that our construction accords with those given the statute by most of our sister circuits that have considered the question. The Third and Sixth Circuits thought that limiting Title III to access as opposed to content was too obvious to warrant additional analysis.[12] The Seventh Circuit also reached the same conclusion, albeit after a more detailed explanation of the practical difficulties of implementing a contrary reading.[13] On the other hand, the Second Circuit read Title III to regulate content as well as access,[14] a reading that

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[11] 42 U.S.C. § 12101(b), from Title III, reads: "It is the purpose of this chapter ... to invoke the sweep of congressional authority ... in order to address the major areas of discrimination faced day-to-day by people with disabilities."

[12] See *Ford* v. *Schering-Plough Corp.*, 145 F.3d 601, 613 (3d Cir.1998) (insurance policy limiting coverage for mental disabilities did not violate Title III); *Parker* v. *Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1012 (6th Cir. 1997) (concluding that Title III does not regulate the content of goods and services).

[13] See *Doe* v. *Mutual of Omaha Ins. Co.*, 179 F.3d 557, 559-63 (7th Cir. 1999), cert. denied, --- U.S. ----, 120 S. Ct. 845, 145 L. Ed.2d 714 (2000) (insurance policy with cap on AIDS coverage did not violate Title III).

[14] See *Pallozzi* v. *Allstate Life Ins. Co.*, 198 F.3d 28, 31-35 (2d Cir. 1999) (refusal to sell life insurance to one with a mental disorder violated Title III).

we ultimately find unpersuasive for the reasons noted above.[15]

C

It follows from our construction of the statute that Time has not violated Title III by offering a policy that limits the amount of coverage for AIDS to $10,000 over the first two years of the policy. The "good" in this case is the insurance policy that Time offered to the members of the Texas Optometric Association. To establish a Title III violation, Mr. McNeil is required to demonstrate that Time denied his son access to that good or interfered with his son's enjoyment of it. Mr. McNeil concedes that Time offered the policy to his son on the same terms as it offered the policy to other members of the association; that is, his son had non-discriminatory access to the good. Mr. McNeil has not alleged that Time interfered with his son's ability to enjoy that policy as it was written and offered to the non- disabled public.[16] Instead, Mr. McNeil's Title III challenge is to a particular provision of the policy – the AIDS limitation. He is, in effect, challenging the content of the good that Time offered. Because Title III does not reach so far as to regulate the content of goods and services, and because it is undisputed this limitation for AIDS is part of the content of the good that Time offered, Mr. McNeil's Title III claim must fail.

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[15] The Second Circuit reasoned that the content of goods and services would need to be altered to allow the disabled the opportunity to fully and equally enjoy those goods and services along with the non- disabled. As already noted, we think such full and equal enjoyment is neither possible nor practicable. In addition, the court relied on the presence of the "safe harbor" provision in Title III for insurers. We address this argument in footnote 11, *supra*.

[16] Although Mr. McNeil may argue that his son was denied access to a service when Time failed to pay the claims beyond $10,000, this is still an attack on the content of the good. The policy did not provide for payment of claims beyond $10,000, so their payment was not a service that Dr. McNeil was entitled to.

We therefore affirm the district court's dismissal of Mr. McNeil's Title III claim.

IV

The district court held that ERISA preempted Mr. McNeil's remaining state law claims and dismissed them. In doing so, the court first determined that Time's policy constituted an ERISA plan, and that the state law claims did not fall within ERISA's safe harbor for the operation of laws regulating insurance. Mr. McNeil takes issue with each of these determinations on appeal.

It is well established that state law claims are preempted if they "relate to" an ERISA plan. ERISA's preemption clause states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employer benefit plan." 29 U.S.C. § 1144(a) (expressly excepting two situations not applicable here).

In reviewing the district court's decision, we must make two separate determinations. First, we need to establish that Time's insurance policy constituted an ERISA plan. This is an issue of fact that we review for clear error. *Zavora* v. *Paul Revere Life Ins. Co.*, 145 F.3d 1118, 1120 (9th Cir. 1998); *Belanger* v. *Wyman-Gordon Co.*, 71 F.3d 451, 454 (1st Cir. 1995). Second, if there is such a plan, we must establish that ERISA does preempt Mr. McNeil's state law claims. This is an issue of law that we review de novo. *Robin* v. *Metropolitan Life Insurance Co.*, 147 F.3d 440, 444 (5th Cir. 1998).

A

Under ERISA, an "employee welfare benefit plan" is defined, in part, as "any plan, fund, or program ... established or maintained by an employer ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). To determine whether a particular plan qualifies as an ERISA plan, we ask whether the plan (1) exists; (2) falls within the safe harbor exclusion

established by the Department of Labor; and (3) meets the ERISA requirement of establishment or maintenance by an employer for the purpose of benefiting the plan participants. *Meredith* v. *Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993).

(1)

We agree with the district court that a plan existed. The district court held that a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. See *id.* (setting out the rule for determining the existence of a plan). This information was clearly available in the brochures Dr. McNeil received.

The plan that existed, moreover, was a single plan covering both Ms. Jay and Dr. McNeil. Before either obtained coverage, Dr. McNeil filled out an employer application. Then, both he and Ms. Jay sent in their individual employee enrollment forms. The partnership then paid the first premium for both of them. After that, premium bills were sent to the partnership and referred to both Ms. Jay and Dr. McNeil. All these factors indicate that the plan, at least as established, included Dr. McNeil. Any concerns we have about the fact that Dr. McNeil usually paid his own premium are not enough to overcome the deference due the district court concerning an issue of fact such as this one. The court held that there was a single plan that included both Ms. Jay and Dr. McNeil, and we cannot say that determination was clear error.[17]

(2)

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[17] It is true that a plan in which the only participants are the owners or partners does not constitute an ERISA benefit plan. *Meredith* v. *Time Ins. Co.*, 980 F.2d 352, 357-58 (5th Cir. 1993). But that is not the case here, because the plan covered both Dr. McNeil and Ms. Jay. See *Vega* v. *Nat. Life Ins. Services, Inc.*, 188 F.3d 287, 291 (5th Cir. 1999) (*en banc*) (plan covering owners and employees constituted ERISA plan); *Peterson* v. *American Life & Health Ins. Co.*, 48 F.3d 404, 408 (9th Cir. 1995) (the involvement of at least one employee is sufficient to establish the existence of an ERISA plan).

To qualify as an ERISA plan, the plan cannot fall within the Department of Labor's "safe harbor" exclusion. ERISA's § 505 granted the Secretary of Labor the authority to promulgate regulations for implementation of ERISA, 29 U.S.C. § 1135,[18] and the Secretary has created an exemption for certain group or group-type insurance programs from the scope of ERISA. 29 C.F.R. § 2510.3-1(j)(1999).[19] We have adopted this "safe harbor" for certain types of claims, and have held that an insurance policy is not governed by ERISA if (1) the employer does not contribute to the plan; (2) par-

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[18] 29 U.S.C. § 1135 reads:

> Subject to subchapter II of this chapter and section 1029 of this title, the Secretary may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter. Among other things, such regulations may define accounting, technical and trade terms used in such provisions; may prescribe forms; and may provide for the keeping of books and records, and for the inspection of such books and records (subject to section 1134(a) and (b) of this title).

[19] 29 C.F.R. § 2510.3-1(j) reads:

> (j) Certain group or group-type insurance programs. For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
>
> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation in the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

ticipation is voluntary; (3) the employer's role is limited to collecting premiums and remitting them to the insurer; and (4) the employer received no profit from the plan. *Meredith*, 980 F.2d at 355. The plan must meet all four criteria to be exempt. *Id.*

Time's plan does not fall within the ERISA safe harbor. As the district court noted, the evidence clearly establishes that the partnership contributed to the plan. Though the partnership's contributions were for Ms. Jay, not Dr. McNeil, all the documents filed with Time indicated that the two were members of the same plan.

(3)

Finally, the plan met the requirements of 29 U.S.C. § 1002(1). First, the single plan was established by the partnership. Dr. McNeil filed an employer application for the partnership and signed a document purporting to bind the partnership. In addition, the partnership paid the initial premium establishing the policy. The bills that Time sent to the partnership, as opposed to each individual, support this conclusion that the partnership established a single plan. The partnership also maintained that plan by paying Ms. Jay's premiums throughout the life of the partnership. Second, the purpose of the plan was to provide the participants, Ms. Jay and Dr. McNeil, with medical care.

Mr. McNeil raises one other argument for the proposition that this plan did not constitute an ERISA plan. He contends that the partnership's involvement in interstate commerce was not sufficient to implicate ERISA under 29 U.S.C. § 1003(a)(1). We cannot agree. Mr. McNeil concedes that the partnership purchased glasses from other states that were then shipped to the office in Texas. Moreover, because Time was not in Texas, even setting up the insurance policy constituted interstate commerce. There is no doubt, therefore, that the partnership was involved in interstate commerce, and

the extent of that involvement, at least for ERISA purposes, is not a matter of degree.

B

ERISA's preemption of state law claims is extensive. We have held that § 1144(a) preempts a state law claim if that claim addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan, and if that claim directly affects the relationship between traditional ERISA entities. *Dial* v. *NFL Player Supplemental Disability Plan*, 174 F.3d 606, 611 (5th Cir. 1999).[20]

Mr. McNeil makes the following state common law claims that have not been addressed on the merits: breach of contract, breach of the duty of good faith and fair dealing, negligent misrepresentation, common law discrimination, waiver, estoppel and ratification. He also argues that various provisions of the Texas Insurance Code requiring sound actuarial principles have been incorporated into state contract law and tort law (under the duty of good faith and fair dealing) when insurance is involved.[21]

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[20] We disagree with Mr. McNeil's argument that our inquiry on this issue has been fundamentally altered by the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed.2d 695 (1995). The method of analysis we use today was well established before that decision, and it continues to be used today. Compare *Weaver* v. *Employers Underwriters, Inc.*, 13 F.3d 172, 176 (5th Cir. 1994) (before *Travelers*); *Memorial Hosp. System* v. *Northbrook Life Ins. Co.*, 904 F.2d 236, 245 (5th Cir. 1990) (same); with *Cypress Fairbanks Medical Center Inc.* v. *Pan-American Life Ins. Co.*, 110 F.3d 280, 283 (5th Cir. 1997) (post-*Travelers*); *Smith* v. *Texas Children's Hospital*, 84 F.3d 152, 155 (5th Cir.1996) (same).

[21] Mr. McNeil also cites to 26 T.A.C. § 26.20(e), 26 T.A.C. § 26.27, and 28 T.A.C. § 21.702, but these are agency regulations and do not provide the foundation for a claim.

We hold that all of these claims are preempted by ERISA.[22] Each claim addresses Mr. McNeil's right to receive benefits under the terms of an ERISA plan. Moreover, these claims directly affect the relationship between Dr. McNeil's estate and Time. A finding for either party will affect the obligations owed to the other under the provisions of the plan. For these reasons, we hold that the district court's determination of ERISA preemption over the state claims was correct.[23]

There is one exception to ERISA preemption, but it does not apply in this case. Mr. McNeil argues that the laws on which he bases his claims fall within ERISA's "savings clause," 29 U.S.C. § 1144(b)(2)(A). That provision states: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.* A law regulates insurance when: (1) it is specifically directed at the insurance industry; (2) it transfers or spreads policyholder risk; and (3) it affects an integral part of the policy relationship between insurer and insured. *Gahn* v. *Allstate Life Ins.*, 926 F.2d 1449, 1453 (5th Cir. 1991). Unfortunately for Mr. McNeil, none of the remaining state law claims satisfies these requirements. Thus, these state laws do not fall within the savings clause.

V

For the reasons stated herein, the district court's decision is, in all respects,

AFFIRMED.

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[22] Because we have federal diversity and federal question jurisdiction, we do not consider the question of complete preemption. See *McClelland* v. *Gronwaldt*, 155 F.3d 507 (5th Cir. 1998).

[23] Mr. McNeil's contentions concerning the incorporation of Texas insurance law's requirement of sound actuarial principles are inherently part of these state law claims. While that requirement might affect resolution of those claims because of incorporation, that does not alter the nature of those claims, and therefore our determination concerning preemption.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
AUG 28 1996
NANCY DOHERTY, CLERK
BY _____ DEPUTY

JIMMY WALLACE McNEIL, Individually, and as Independent Executrix and representative of the ESTATE OF MICHAEL JAY McNEIL, Plaintiff,

VS.

TIME INSURANCE COMPANY, Defendant.

Civil Action No. 3:95-CV-0382-G

MEMORANDUM ORDER

Before the court is the first supplemental motion ("first motion") and the second supplemental motion ("second motion") of the defendant, Time Insurance Company ("Time"), for summary judgment. For the following reasons, Time's first motion is granted and Time's second motion is denied.

II. BACKGROUND

The plaintiff, Michael Jay McNeil ("McNeil"), a licensed professional optometrist, was a member of the Texas Optometrist Association ("TOA"). Plaintiff's Second Amended Complaint ("Complaint") ¶ 4. Through his membership in TOA McNeil purchased and received a certificate of insurance from Time. *Id.* McNeil contends that the policy provided him with comprehensive health and medical benefits and life insurance, with maximum lifetime benefits of $2,000,000.00. *Id.*

In September 1994, McNeil was diagnosed with Acquired Immune Deficiency Syndrome ("AIDS") and from that time, until his death, required extensive medical treatment. *Id.* ¶ 5.

In November and December, 1994, McNeil incurred medical expenses related to his AIDS condition in excess of $400,000.00, which he submitted to Time as claims under the policy. *Id.* McNeil contends that Time denied these claims on the ground that AIDS was not covered or that coverage in 1994 was limited to $10,000.00. *Id.* McNeil alleges that his psychological and physical condition deteriorated and that he endured severe pain and suffering as a direct result of Time's denial of coverage. *Id.* ¶ 7.

In this action, McNeil[1] asserts claims for breach of contract, breach of the duty of good faith and fair dealing, negligent misrepresentation, common law discrimination, waiver, estoppel and ratification, and violations of the Texas Deceptive Trade Practices Act, Article 21.21 of the Texas Insurance Code, §§ 21.001 *et seq.* of the the Texas Commission on Human Rights Act, the Texas Labor Code, the Americans with Disabilities Act ("ADA"), and the Employee Retirement Income Security Act ("ERISA"). In response to these claims, Time filed its original motion for summary judgment on May 10, 1995. Time then filed a first supplemental motion for summary judgment on May 30, 1995 and a second supplemental motion for summary judgment on January 29, 1996.[2]

Time's first motion contends that, as a matter of law, McNeil's claim for violation of the ADA is without merit. This motion is granted. Time's second motion maintains that McNeil's policy is, as a matter of law, governed by ERISA. This motion is denied.

II. ANALYSIS

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[1] McNeil died on March 1, 1995. Jimmy Wallace McNeil, individually and as independent executrix and representative of McNeil's estate, has continued to maintain the action against Time.

[2] Time's supplemental motions for summary judgment rendered its original motion for summary judgment moot. Accordingly, on June 24, 1996, that motion was denied as moot.

A. Evidentiary Burdens on Motion for Summary Judgment

Summary judgment is proper when the pleadings and evidence on file show that no genuine issue exists as to any material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).[3] "[T]he substantive law will identify which facts are material." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The movant makes such a showing by informing the court of the basis of its motion and by identifying the portions of the record which reveal there are no genuine material fact issues. See *Celotex Corporation v. Catrett,* 477 U.S. 317, 323 (1986). Once the movant makes this showing, the nonmovant must then direct the court's attention to evidence in the record sufficient to establish that there is a genuine issue of material fact for trial. *Id.* at 323-24. To carry this burden, the opponent must do more than simply show some metaphysical doubt as to the material facts. *Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corporation, 475* U.S. 574, 586 (1986). Instead, he must show that the evidence is sufficient to support a resolution of the factual issue in his favor. *Anderson,* 477 U.S. at 249. All of the evidence must be viewed, however, in a light most favorable to the motion's opponent. *Id.* at 255 (citing *Adickes v. S.H. Kress & Co.,* 398 U.S. 144, 158-59 (1970)). Summary judgment is properly entered against a party if after adequate time for discovery, he fails to establish the existence of an element essential to his case and as to which he will bear the burden of proof at trial. *Celotex,* above, 477 U.S. at 322-23.

B. McNeil's ADA Title I Claim

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[3] The disposition of a case through summary judgment "reinforces the purpose of the Rules, to achieve the just, speedy, and inexpensive determination of actions, and, when appropriate, affords a merciful end to litigation that would otherwise be lengthy and expensive." *Fontenot v. Upjohn Company,* 780 F.2d 1190, 1197 (5th Cir. 1986).

McNeil alleges a violation of Title I of the ADA, 42 U.S.C. §12112(a) ("Title I"). Complaint ¶¶ 28-30. Time's first motion contends that McNeil cannot recover under Title I because he failed to exhaust administrative remedies before commencing this action. The court agrees.

Failure to exhaust administrative remedies is a jurisdictional bar to bringing suit under Title I of the ADA. 42 U.S.C. § 12117(a) (the powers, remedies, and procedures set forth in Title VII of the Civil Rights Act of 1964 apply to Title I of the ADA as well). "It is well-settled that courts have no jurisdiction to consider Title VII claims as to which the aggrieved party has not exhausted administrative remedies." *National Association of Government Employees v. City Public Service Board of San Antonio, Texas,* 40 F.3d 698, 711 (5th Cir. 1994) (citing *Tolbert v. United States,* 916 F.2d 245, 247-48 (5th Cir. 1990)).

Here, McNeil did not file a charge of discrimination with the Equal Employment Opportunity Commission before instituting this case. Furthermore, McNeil is time-barred from curing this defect. 42 U.S.C. § 2000*e*-5(e); *Delaware State College v. Ricks,* 449 U.S. 250 (1980). Accordingly, Time is entitled to judgment on this claim as a matter of law.

C. McNeil's ADA Title III Claim

McNeil also alleges a violation of Title III of the ADA, 42 U.S.C. §§ 12182(a, b) ("Title III"). Complaint ¶¶ 28-30. Time argues in its first motion that its provision of insurance benefits does not constitute a "public accommodation" as that term is defined in Title III[4] and, therefore, McNeil's claim of discrimination under Title III must fail. First Motion at 6-7. This court agrees.

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[4] Title III's definition of public accommodation includes a "laundromat, drycleaner, bank, barber shop, beauty shop, . . . pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment." 42 U.S.C. § 12181(7)(F).

Title III addresses disability-based discri nation that prevents equal access to places of "public accommodation." 42 U.S.C. § 12181 *et seq.* Title III provides in part that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12182(a). McNeil has alleged that Time is an owner, lessor or operator of a place of public accommodation. Complaint ¶ 29.

The court must therefore decide whether the provision of health insurance benefits is a "public accommodation" within the meaning of Title III. In his response, McNeil asserts that Title III applies to insurance companies as public accommodations. To support this contention, McNeil relies on *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Association of New England, Inc.*, 37 F.3d 12 (1st Cir. 1994).

In *Carparts,* the plaintiff's insurance carrier amended its coverage to limit benefits for AIDS-related illnesses to $25,000. *Id.* at 14. The plaintiff filed suit asserting a claim for relief under Title III. *Id.* at 14-15. The district court, interpreting the term "public accommodation" as "being limited to actual physical structures with definite physical boundaries which a person physically enters for the purpose of utilizing the facilities or obtaining services therein," dismissed the plaintiff's Title III claim. *Id.* at 18. The First Circuit, holding that the term "public accommodation" is not limited to actual physical structures, vacated the district court's judgment and remanded the case for further proceedings. *Id.* at 19, 21. The *Carparts* court determined that to "limit the application of Title III to physical structures which persons must enter to obtain goods and services would run afoul of the purposes of the ADA and would severely frustrate Congress's intent that individuals with disabilities fully enjoy the goods, services,

privileges and advantages, available indiscriminately to other members of the general public." *Id.* at 20.

The issue is one of first impression in this circuit. In the absence of guidance from the Fifth Circuit, this court declines to follow *Carparts'* broad interpretation of the term "public accommodation." To the contrary, the court is persuaded by the reasoning of *Pappas v. Bethesda Hospital Association,* 861 F. Supp. 616 (S.D. Ohio 1994).

In *Pappas,* the plaintiff's employer denied her family health coverage because her husband was receiving medication for hypertension and hyperlipidemia, and her son was a paraplegic confined to a wheelchair. *Id.* at 617. The plaintiff filed suit, alleging discrimination in violation of Title III. *Id.* Basing its decision on the ordinary and common meaning of the words used in the statute, the court held that the scope of Title III's antidiscrimination provision is clearly limited to the inability to make physical use of the services of a place of public accommodation. *Id.* at 620. The court assumed that the plaintiff had been denied insurance coverage by the defendants but nonetheless concluded that she had not been denied any physical use of the defendants' services. *Id.* On this basis, the court decided that "there is no nexus whatsoever between the alleged discrimination and any public accommodation" and dismissed the plaintiff's Title III claim for failure to state a claim upon which relief could be granted. *Id.*

According to the complaint in the instant case, while McNeil was not denied any physical use of Time's services,[5] his insurance policy was limited with respect to its provision of benefits for the treatment of AIDS Under the interpretation of public accommodation" in *Pappas,* this action does not come within the scope of Title III's antidiscrimination provision. *Id.* at 619-20; *Parker v. Metropolitan Life Insur-*

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[5] Time does not contest that to deny McNeil physical access or use to any of its services on account of his disability would constitute a violation of Title III.

ance Company, 875 F. Supp. 1321, 1327-1328 (W.D. Tenn. 1995). Here, as in *Pappas* and *Parker,* there is no nexus between the alleged discrimination against McNeil and his inability to make physical use of any of Time's services. Accordingly, McNeil's claim for discrimination under Title III must fail.

C. Whether McNeil's Policy is Governed by ERISA In its second motion, Time maintains that McNeil's policy is governed by ERISA and that, as a result, his claims for relief under state law are preempted. For Time to prevail on this defense, it must prove that the policy was indeed an ERISA plan. *Gorman v. Life Insurance Company of North America,* 811 S.W.2d 542, 546 n.7 (Tex.), *cert. denied,* 502 U.S. 824 (1991) (citing *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. 724, 741 (1985) ("[t]he presumption is against pre-emption")).

Time has failed to meet its burden of establishing the absence of any material issue of fact regarding ERISA preemption. *Celotex,* 477 U.S. at 323. Accordingly, Time's second motion for summary judgment is denied.

III. CONCLUSION

In response to Time's denial of benefits for AIDS-related treatments, McNeil brought this case asserting both state and federal claims. Time then moved for summary judgment on grounds that McNeil is barred from maintaining a cause of action under Title I of the ADA and that Time's alleged conduct does not discriminate against McNeil under Title III of the ADA. Upon review of these contentions, the court concludes that they are meritorious. Accordingly, Time's first motion for summary judgment is **GRANTED**.

Time also maintains, in its second motion for summary judgment, that the policy in question is governed by ERISA so that McNeil's state law claims are preempted. The court concludes, however, that Time has failed to establish the absence of a material issue of fact as to whether ERISA controls

these claims. Accordingly, Time's second motion for summary judgment is **DENIED**.

SO ORDERED.

August 28,1996.

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A. JOE FISH
United States District Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

JIMMY WALLACE McNEIL, Individually, and as Independent Executrix and representative of the ESTATE OF MICHAEL JAY McNEIL, Plaintiff,

VS.

TIME INSURANCE COMPANY, Defendant.

Civil Action No. 3:95-CV-0382-G

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
APR -3 1997
NANCY DOHERTY, CLERK
BY _____ DEPUTY

ORDER

Before the court is the motion of the plaintiff Jimmy Wallace McNeil ("McNeil") for reconsideration, in light of *Parker v. Metropolitan Life Insurance Company,* 99 F.3d 181 (6th Cir. 1996), of the court's August 28, 1996 memorandum order granting partial summary judgment in favor of the defendant, Time Insurance Company. McNeil's primary ground for relief is that "the central opinion" relied on by the court in its August 28, 1996 memorandum order, *Parker v. Metropolitan Life Insurance Company,* 875 F. Supp. 1321, 1327-28 (W.D. Tenn. 1995), has been reversed on appeal. Plaintiffs' Motion for Reconsideration in Light of *Parker v. Metropolitan Life Ins. Co.* of Order Granting Defendant's Motion for Summary Judgment in Part and Brief in Support Thereof at 2.

It is true that the district court's opinion in *Parker* was reversed, in part, by the Sixth Circuit. *Parker,* 99 F.3d at 183-84. However, the Sixth Circuit later granted a petition for rehearing *en banc* and vacated its decision in *Parker. Parker v. Metropolitan Life Insurance Company,* No. 95-5269 (6th

Cir. Feb. 6, 1997) (order vacating decision and judgment and restoring case to docket as pending appeal) (attached as Exhibit A to Time Insurance Company's Surreply to Plaintiff's Motion for Reconsideration in Light of *Parker v. Metropolitan Life Insurance Company*).

In light of this action, McNeil's sole ground for reconsideration no longer exists. The motion for reconsideration is accordingly **DENIED.**

SO ORDERED.

April 3 1997.

A. JOE FISH
United States District Judge

APPENDIX D

1997 WL 182274

United States District Court,
N.D. Texas.

Jimmy Wallace McNEIL, Individually, and as Independent Executrix and Representative of the Estate of Michael Jay McNeil, Plaintiff,
v.
TIME INSURANCE COMPANY, Defendant.

Civil Action No. 3:95-CV-0382-G.
April 3, 1997.

MEMORANDUM ORDER

FISH, District Judge.

Before the court is the second motion of the defendant, Time Insurance Company ("Time"), for summary judgment. Also before the court is the motion of the plaintiff, Jimmy Wallace McNeil ("McNeil"), for partial summary judgment. For the reasons stated below, the first of these motions is granted and the second is denied.

I. BACKGROUND

This suit involves numerous state and federal claims, all founded on allegations that Time wrongfully denied McNeil's[1] claims under a group insurance policy. This action has been the subject of a prior opinion by the court; therefore, the court does not repeat all the relevant facts herein but refers to its August 28, 1996 memorandum order for pertinent

[1] McNeil died on March 1, 1995. Since that time, Jimmy Wallace McNeil, individually and as independent executrix of McNeil's estate, has prosecuted this action.

background. See *McNeil* v. *Time Insurance Company*, No. 95-CV-0382-G, slip op. at 1-3 (N.D.Tex. Aug. 28, 1996).

The particular issues now before the court relate to the enforceability of a clause in the insurance policy ("the policy") at issue in this case. In April 1994, McNeil was offered health insurance coverage by Time through his membership in the Texas Optometrist Association ("TOA"). Deposition of Frank Kyle ("Kyle Depo. Pt. I") at 119-20, attached as Exhibit B to Appendix in Support of Defendant's Second Motion for Summary Judgment ("First Appendix"); Plaintiffs' Second Amended Complaint ("Complaint") ¶ 4. Frank Kyle, the agent marketing Time's coverage to the TOA, provided TOA's members with a brochure which described the coverage limitations for Acquired Immune Deficiency Syndrome ("AIDS") contained in Time's policy. Kyle Depo. Pt. I at 119-20; Group Portfolio Texas Brochure ("Brochure") at 7, attached as Exhibit 18 to Kyle Depo Pt. I. The brochure stated that persons having AIDS or AIDS Related Complex ("ARC") could receive a $10,000 maximum benefit for the first 24-month period and thereafter could receive the policy's maximum benefit. Brochure at 7. The brochure also set forth coverage limits for Temporomandibular Joint Dysfunction ("TMJ") and Psychiatric/Substance Abuse. Id.

On April 27, 1994, the practice in which McNeil worked, Dickey & McNeil, Optometrists ("the partnership"), applied for coverage with Time for McNeil and another employee. Deposition of Roy F. Dickey, O.D. at 47-48, attached as Exhibit D to Appendix in Support of Defendant's Second Supplemental Motion for Summary Judgment and Reply to Plaintiff's Response to Motion for Summary Judgment ("Second Appendix"); Employer Participation Agreement/Application, attached as Exhibit 20 to Deposition of Frank Kyle ("Kyle Depo. Pt. II"), attached as Exhibit C to Second Appendix. McNeil also submitted an enrollment form for himself. Group Insurance Employee Enrollment Form, attached as Exhibit B to Affidavit of Rita Love in Sup-

port of Defendant's Motion for Summary Judgment ("Love Affidavit").

On May 1, 1994, Time accepted the partnership's application and issued certificate booklets for the covered employees. Love Affidavit ¶ 5; Deposition of Rita C. Love ("Love Depo.") at 112, attached as Exhibit A to First Appendix; Group Insurance Certificate ("the booklet"), attached as Exhibit C to Love Affidavit. The booklet, which was approved by the Texas Department of Insurance, restated the coverage limitation for AIDS set forth in the brochure but did so in the section entitled "Covered Medical Services" rather than in the section entitled "General Exclusions." Love Depo. at 112-13; Booklet § 3, ¶ 11.

Time now moves for summary judgment on the ground that the coverage limitation for AIDS is enforceable. Defendant's Second Motion for Summary Judgment ("Motion") at 3. McNeil contends that Time is not entitled to summary judgment, and that he is, because the limitation (1) violates Tex.Ins.Code Ann. arts. 21.21-3 & -6; (2) is ambiguous; and (3) violates the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. ("the ADA"). Plaintiff's (1) Response to Defendant's Second Motion for Summary Judgment and (2) Supplemental Response to Defendant's First and Second Motions for Summary Judgment and Brief in Support Thereof ("Response") at 6 n. 3, 11.

II. ANALYSIS

A. Evidentiary Burdens on Motion for Summary Judgment

Summary judgment is proper when the pleadings and evidence on file show that no genuine issue exists as to any material fact and that the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c).[2] "[T]he substantive law

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[2] The disposition of a case through summary judgment "reinforces the purpose of the Rules, to achieve the just, speedy, and inexpensive determination of actions, and, when appropriate, affords a merciful end to liti-

will identify which facts are material." *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S. Ct. 2505, 91 L. Ed.2d 202 (1986). The movant makes such a showing by informing the court of the basis of its motion and by identifying the portions of the record which reveal there are no genuine material fact issues. See *Celotex Corporation* v. *Catrett*, 477 U.S. 317, 323, 106 S. Ct. 2548, 91 L. Ed.2d 265 (1986). Once the movant makes this showing, the nonmovant must then direct the court's attention to evidence in the record sufficient to establish that there is a genuine issue of material fact for trial. *Id.* at 323-24. To carry this burden, the opponent must do more than simply show some metaphysical doubt as to the material facts. *Matsushita Electric Industrial Co., Ltd.* v. *Zenith Radio Corporation*, 475 U.S. 574, 586, 106 S. Ct. 1348, 89 L. Ed.2d 538 (1986). Instead, he must show that the evidence is sufficient to support a resolution of the factual issue in his favor. *Anderson*, 477 U.S. at 249. All of the evidence must be viewed, however, in a light most favorable to the motion's opponent. Id. at 255 (citing *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 158-59, 90 S. Ct. 1598, 26 L. Ed.2d 142 (1970)). Summary judgment is properly entered against a party if after adequate time for discovery, he fails to establish the existence of an element essential to his case and as to which he will bear the burden of proof at trial. *Celotex*, above, 477 U.S. at 322-23.

B. Articles 21.21-3 & -6 of the Texas Insurance Code

McNeil alleges that the limitation on AIDS coverage in Time's policy violates TEX.INS.CODE ANN.ART. 21.21-3 (Vernon Supp.1994) ("Article 21.21- 3") and is therefore unenforceable. Response at 11; Plaintiffs' Supplemental Brief in Response to Defendant's Motions for Summary Judgment ("Supplemental Brief") at 2-3. Time contends that Article 21.21-3 is inapplicable to the AIDS limitation. Defendant's

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gation that would otherwise be lengthy and expensive." *Fontenot* v. *Upjohn Company*, 780 F.2d 1190, 1197 (5th Cir.1986).

Reply to Plaintiff's Response to Defendant's Second Motion for Summary Judgment ("Reply") at 4-6. The court agrees.

Article 21.21-3,[3] entitled "Discrimination Against Handicapped Prohibited," provides that

> [a]n insurer who delivers or issues for delivery or renews any insurance in this state may not refuse to insure, refuse to continue to insure, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of handicap or partial handicap, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

Id. The issue for this court to decide is whether the definition of "handicap" as that term is used in Article 21.21-3 may include persons with AIDS. The court concludes that it does not.

Article 21.21-3 was enacted in 1983, the same year in which the Texas legislature enacted the Texas Commission on Human Rights Act ("TCHRA"). See Tex.Rev.Civ.Stat.Ann. art. 5221k (Vernon 1987) (repealed 1993). The TCHRA prohibited discrimination in employment against handicapped persons and defined "handicap" to mean "a condition either mental or physical that includes mental retardation, hardness

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[3] This article was repealed in 1993 and was replaced by Tex.Ins.Code Ann. Art. 21.21-6 (Vernon Supp.1997) ("Article 21.21- 6"). When enacting Article 21.21-6, the Texas legislature provided that "[t]his Act takes effect September 1, 1995, and applies only to an insurance policy or an evidence of coverage that is delivered, issued for delivery, or renewed on or after January 1, 1996. A policy or evidence of coverage that is delivered, issued for delivery, or renewed before January 1, 1996 is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose." Id. (Historical and Statutory Notes). In view of the fact that McNeil obtained his coverage from Time prior to January 1, 1996, his claims under Article 21.21-6 are meritless.

of hearing, deafness, speech impairment, visual handicap, being crippled, or any other health impairment that requires special ambulatory devices or services...." *Id.* § 2.01(7)(B).

Although McNeil urges the court to construe the term "handicap" as the term "disability" is used in ADA jurisprudence, Response at 14, 16-17, the ADA is a federal statute and was enacted nearly seven years after Article 21.21-3 and the TCHRA. Therefore, the definition of "handicap" in the TCHRA is a more persuasive guide for this court when interpreting Article 21.21-3 than is the definition of "disability" in the ADA.[4]

In *Hilton* v. *Southwestern Bell Telephone Company*, 936 F.2d 823 (5th Cir. 1991), cert. denied, 562 U.S. 1048 (1992), the Fifth Circuit rejected the view that the definition of "handicap" and "handicapped person" used in the TCHRA included AIDS and its related conditions. The court reasoned that "the element common to each of the ... physical conditions in the statutory list [accompanying the definition of

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[4] The court is aware that the TCHRA was amended in 1989 in part to substitute the term "disability" for the term "handicap." See Tex.Rev.Civ.Stat. Ann. Art. 5221k, § 2.01(4) (Vernon Supp.1990). However, the newly-enacted provision explicitly stated that the term "disability" "does not include ... a person with a currently communicable disease or infection, including ... acquired immune deficiency syndrome...." Id. ¶ (B). Moreover, this change preceded the enactment of the ADA and was not accompanied by a change to the language of Article 21.21-3, which the Texas legislature left in its original form until repealing it in 1993. Therefore, even though some courts have found that AIDS is a disability within the purview of the ADA, Response at 16-17, the court does not consider the term "disability" as used in the ADA or the interpretation given it by the courts to be controlling in determining the meaning of the term "handicap" in Article 21.21-3. See *Hilton* v. *Southwestern Bell Telephone Company*, 936 F.2d 823, 831-32 (5th Cir.1991) (declining to be guided by term "individual with handicaps" used in Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq.*, because Texas legislature chose not to employ or refer to this term when enacting TCHRA (quoting *Chevron Corporation* v. *Redmon*, 745 S.W.2d 314, 317-18 (Tex.1987))), *cert. denied*, 502 U.S. 1048 (1992).

"handicap" and "handicapped person" ... is that each is a physiological rather than pathological condition of physical health." *Id.* at 828.

The reasoning and holding in Hilton persuade this court that the terms "partial handicap" and "handicap" as used in Article 21.21-3, when considered in light of the definition of "handicap" and "handicapped person" provided in the TCHRA, do not include AIDS or its related conditions. If, as Hilton holds, the Texas legislature meant the TCHRA to include only physiological and not pathological conditions, it is logical to conclude that the legislature meant the same language in Article 21.21-3 only to ban the limitation of insurance coverage on the basis of a physiological impairment. This conclusion is bolstered by a regulation promulgated by the Texas Department of Insurance, effective the year in which Article 21.21-3 was enacted, that defines as an unfairly discriminatory act or practice "limiting the ... extent ... of coverage ... solely because of a physical or mental impairment...." 28 TEX. ADMIN.CODE § 21.702 (West 1983). In short, the Fifth Circuit has found that AIDS is not a "handicap" because it does not amount to a physiological impairment, and thus the court cannot conclude that the limitation on AIDS coverage in Time's policy discriminates on the basis of a "handicap" in violation of Article 21.21-3. See *Central Power & Light Company* v. *Bradbury*, 871 S.W.2d 860, 863-64 (Tex.App.--Corpus Christi 1994, writ denied) (holding that eczema is not "handicap" under TCHRA because it "was not based upon mental retardation, hardness of hearing, deafness, speech impairment, visual handicap, being crippled, nor upon any health impairment requiring special ambulatory devices or services").

It is important to add that Article 21.21-3 aims to prevent discrimination in the provision of insurance rather than to prohibit insurers from placing limitations on their coverage. As Time points out, the group insurance policy it provided to the partnership was the same one it provided to all its other

group insureds; Time did not restrict McNeil's coverage because of his disability. Reply at 6. The policy issued to McNeil contained numerous other coverage limitations, viz., for TMJ, medical conditions worsened by pregnancy, psychiatric conditions and substance abuse, and organ transplantation. Booklet § 3, ¶¶ 13, 15-16, 18. If the court were to accept McNeil's argument that the limitation on AIDS coverage in Time's policy is discriminatory under Article 21.21-3, these other limitations would be susceptible to a similar analysis. The court, however, is unwilling to give Article 21.21-3 such wide application, especially in light of the Fifth Circuit's narrow construction of the term "handicap" in *Hilton*.

Accordingly, Time, and not McNeil, is entitled to summary judgment on McNeil's Article 21.21-3 claim.[5]

C. Ambiguity in the Terms of Time's Policy

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[5] In deciding the instant motions, the court has treated McNeil's claim under Article 21.21-3 as an action for damages under the Texas Deceptive Trade Practices Act, Tex.Bus. & Com.Code Ann. § 17.50(a)(4) (Vernon 1987), which provides that "[a] consumer may maintain an action" where "the use or employment by any person of an act or practice in violation of Article 21.21, Texas Insurance Code ... or rules or regulations issued by the State Board of Insurance under Article 21.21, Texas Insurance Code" constitutes "a producing cause of actual damages." McNeil contends that the "remedies" provision found at Tex.Ins.Code Ann. Art. 21.21, § 16 enables him to maintain a private cause of action directly under Article 21.21-3 for Time's alleged violations of that article. Complaint ¶ 22; Supplemental Brief at 5. The Supreme Court of Texas, however, rejected a similar argument made by an insured with respect to Tex.Ins.Code Ann. Art. 21.21-2. See *Vail* v. *Texas Farm Bureau Mutual Insurance Company*, 754 S.W.2d 129, 134 (Tex.1988) (holding that although Tex.Ins.Code Ann. Art. 21.21-2, which prohibits unfair settlement practices, does not confer a private cause of action, insured nevertheless stated a cause of action for violation of this article under Tex.Bus. & Com.Code Ann. § 17.50(a)(4) together with Tex.Ins.Code Ann. Art. 21.21, § 16) (citing *McKnight* v. *Ideal Mutual Insurance Company*, 534 F. Supp. 362, 364 (N.D.Tex.1982)).

McNeil contends that Time is not entitled to summary judgment on the AIDS coverage limitation in Time's policy because, under relevant Texas law regarding the interpretation of contracts, the "[p]olicy is ... inherently ambiguous." Response at 6 n. 3.

In construing a contract, the court must determine whether its meaning is ambiguous. "Whether a contract is ambiguous is a question of law for the court to decide by looking at the contract as a whole...." *National Union Fire Insurance Company of Pittsburgh, Pennsylvania* v. *CBI Industries*, 907 S.W.2d 517, 520 (Tex.1995); see also *Brooks, Tarlton, Gilbert, Douglas, & Kressler* v. *United States Fire Insurance Company*, 832 F.2d 1358, 1364 (5th Cir. 1987) (applying Texas law). A written contract is ambiguous if its language "is subject to two or more reasonable interpretations" but is not ambiguous if it is "so worded that it can be given a definite or certain legal meaning." *CBI Industries*, 907 S.W.2d at 520. Mere disagreement between the parties about the correct interpretation of the term will not render the term ambiguous, nor will it transform the issue of law into an issue of fact. *D.E.W., Inc.* v. *Local 93, Laborers' International Union of North America*, 957 F.2d 196, 199 (5th Cir. 1992).

Where an insurance policy term is ambiguous, the court will construe that term in favor of the insured. *Toops* v. *Gulf Coast Marine Inc.*, 72 F.3d 483, 486 (5th Cir. 1996) (quoting *Adams* v. *John Hancock Mutual Life Ins. Co.*, 797 F. Supp. 563, 567 (W.D.Tex.1992) [*aff'd*, 49 F.3d 728 (5th Cir. 1995) (table)]). In addition, when construing a policy term that excludes or limits coverage, the court must adopt any reasonable interpretation of the exclusion urged by the insured, even if the interpretation of the insurer appears more reasonable or a more accurate reflection of the parties' intent. *Id.*

These rules of construction, however, apply only when the terms of the policy are ambiguous. *Ranger Insurance Company* v. *Bowie*, 574 S.W.2d 540, 542 (Tex.1978). The court will not alter the clear terms of an insurance policy or strain to

find an ambiguity where none exists. *Calcasieu-Marine National Bank of Lake Charles* v. *American Employers' Insurance Co.*, 533 F.2d 290, 296 (5th Cir.), *cert. denied*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976) (Louisiana law); *Vest* v. *Gulf Insurance Company*, 809 S.W.2d 531, 533 (Tex.App.--Dallas 1991, *writ denied*). See *State Farm Lift Insurance Company* v. *Beaston*, 907 S.W.2d 430, 433 (Tex.1995) (only if an insurance policy remains ambiguous despite ordinary canons of contract construction should a court construe its language against the insurer in a manner that favors coverage).

Viewing McNeil's policy as a whole, the court concludes that the limitation on AIDS coverage contained within it is not ambiguous. While that limitation appears under the heading "covered medical services" rather than under the heading "general exclusions," this does not render the policy's terms ambiguous. Because the policy does provide coverage for AIDS, it is logical for the terms of that coverage to appear with the other provisions setting out the extent of the policy's coverage rather than with provisions setting forth procedures and medical expenses not covered at all.

McNeil argues that the policy ambiguously describes its coverage for AIDS treatment because, in its initial section, it declares the lifetime maximum benefit to be $2,000,000 and, in a subsequent section, it sets forth a limitation on AIDS coverage. Response at 6 n. 3. Although the policy's meaning may be unclear if these provisions are read in isolation, the court must decide the question of ambiguity by "looking at the contract as a whole...." *CBI Industries*, 907 S.W.2d at 520. Because the policy clearly states the extent of coverage it provides for AIDS treatment, it may be given a "definite [and] certain legal meaning" and is therefore not ambiguous. *Id.*

D. The ADA

In the court's August 28, 1996 memorandum order, which was issued after McNeil filed his responses to the instant motions, the court ruled that McNeil was not entitled to recover under either Title I or Title III of the ADA. McNeil, No. 95-CV-0382-G, slip op. at 4-9. Therefore, McNeil's argument that Time's policy violates the ADA is moot.

E. McNeil's Motion for Partial Summary Judgment

McNeil has moved for partial summary judgment on the ground that Time has violated Articles 21.21-3 & -6 and Title III of the ADA. Response at 11. Because the court has determined that Time is entitled to summary judgment as to each of these statutory provisions, it concludes that McNeil's motion is without merit.

III. CONCLUSION

As in *Hilton*, "[t]he historical facts of this case exemplify an often replicated modem tragedy, evoking the sympathy of this court and ... thereby making more difficult the decisions...." *Hilton*, 936 F.2d at 825. However, after careful consideration of the briefs and record in this case, the court concludes that the AIDS coverage limitation in Time's policy does not violate Articles 21.21-3 & -6 or the ADA and is not ambiguous. Accordingly, Time's second motion for summary judgment is GRANTED, and McNeil's motion for partial summary judgment is DENIED.

SO ORDERED.

APPENDIX E

1997 WL 340952

United States District Court, N.D. Texas.

Jimmy Wallace McNEIL, Individually, and as Independent Executrix and Representative of the Estate of Michael Jay McNeil, Plaintiff,

v.

TIME INSURANCE COMPANY, Defendant.

No. CIV.A. 395CV0382G.
June 12, 1997.

MEMORANDUM ORDER

FISH

Before the court is the motion of the plaintiff Jimmy Wallace McNeil ("McNeil") for reconsideration of the court's April 3, 1997[1] memorandum order granting summary judgment in favor of defendant, Time Insurance Company, on McNeil's claim under TEX. INS.CODE ANN. art. 21.21.3 (Vernon Supp.1994) ("Article 21.21-3"). McNeil argues that the court erred when it relied on case law interpreting the Texas Commission on Human Rights Act ("TCHRA"), TEX.REV.CIV. STAT. ANN. art. 522lk (Vernon 1987) (repealed 1993), to determine whether the definition of "handicap," as that term is used in Article 21.21-3, includes persons with Acquired Immune Deficiency Syndrome ("AIDS"). Plaintiffs' Motion for Reconsideration of Court's Memorandum Order Dated March 3, 1997 and Brief in Support

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[1] Although McNeil's motion references a memorandum order dated March 3, 1997, a review of the docket sheet for this case indicates that no memorandum order was issued on March 3, 1997, and it is clear from McNeil's arguments that he moves the court to reconsider its memorandum order dated April 3, 1997.

Thereof ("Motion") at 1. McNeil contends that the court should have relied on a provision of the Texas Administrative Code which provides that, for purposes of Article 21.21-3, the term "handicap" means "a physical or mental impairment which substantially limits one or more of the person's major life activities." 28 TEX. ADMIN. CODE § 21.703; see Motion at 2.

Contrary to McNeil's assertions, it does not necessarily follow from this provision that AIDS is a "handicap" under Article 21.21-3. The question remains whether, under Texas law, AIDS is included in the phrase "physical or mental impairment which substantially limits one or more of the person's major life activities." While various courts have construed AIDS to be included in language similar to that used in federal disability discrimination statutes, McNeil has failed to direct the court's attention to any Texas case reaching a similar conclusion in applying Texas law. In fact, the Texas legislature has specifically provided that the term "disability," which it defines as "a mental or physical impairment that substantially limits at least one major life activity of [an] individual," "does not include ... acquired immune deficiency syndrome...." Tex. Lab.Code Ann. § 21.002(6)(B) (Vernon 1996). This language is especially significant because it is drawn from the Texas disability discrimination statute and demonstrates that, with respect to the classification of AIDS as a handicap under Texas law, McNeil's reliance on case law construing the federal disability discrimination statutes is misplaced.

Therefore, even assuming that the court chose to apply the definition given the term "handicap" in 28 Tex. Admin. Code § 21.703,[2] that definition does not vitiate the court's conclu-

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[2] It is well established in Texas that "[a]n administrative agency may use its discretion in interpreting an applicable statute, but the courts are not bound by such administrative construction...." *State ex rel. Employers Mutual Liability Insurance Company of Wisconsin* v. *United Bonding Insurance Company*, 450 S.W.2d 689, 692 (Tex.Civ.App.--Austin 1970, no

sion that the term "handicap," as used in Article 21.21-3, does not apply to persons with AIDS. Accordingly, McNeil's motion for reconsideration is DENIED.[3]

SO ORDERED.

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writ) (citing *Board of adjustment* v. *Underwood*, 332 S.W.2d 583 (Tex.Civ.App.--San Antonio 1960, writ ref'd n.r.e.)); see also *Pension Board of the Police Officers Pension System of Houston, Texas* v. *Colson*, 492 S.W.2d 307, 309 (Tex.Civ.App.--Beaumont 1973, writ ref'd n.r.e.).

[3] McNeil also moves the court to reconsider its analysis of whether Article 21.21-3 confers a private cause of action. Motion at 4- 13. However, in view of the court's decision to adhere to its conclusion that the term "handicap," as used Article 21.21-3, does not apply to persons with AIDS, it declines to revisit the question of whether McNeil may sue directly under Article 21.21-3.

APPENDIX F

977 F. Supp. 424

United States District Court,
N.D. Texas,
Dallas Division.

Jimmy Wallace McNEIL, Individually, and as Independent Executor and Representative of the Estate of Michael Jay McNeil, Plaintiffs,
v.
TIME INSURANCE COMPANY, Defendant.

Civil Action No. 3:95-CV-0382-G.
Sept. 10, 1997.

Cynthia Anne Leiferman, Dallas, TX, for Plaintiffs.

Andrew George Jubinsky, Timothy Alan Daniels, Figari & Davenport, Dallas, TX, for Defendant.

MEMORANDUM OF DECISION

FISH, District Judge.

On June 24, 1997, a nonjury trial was held in this cause to decide the question whether the plaintiffs' state law claims are preempted by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. ("ERISA"). Concluding that ERISA does preempt these claims, the court herein delivers its findings of fact and conclusions of law. Any finding of fact below may be deemed a conclusion of law, and any conclusion may be deemed a finding of fact.

I. FINDINGS OF FACT

On November 14, 1992, the plaintiff, Michael Jay McNeil ("McNeil"),[1] who was a member of the Texas Optometric Association ("TOA"), applied for health coverage from National American Life Insurance Company of Pennsylvania ("NALICO") as a sole proprietor/independent contractor. Trial Transcript ("TR") at 11, 17; Defendant's Exhibit ("DX") 24. The application for NALICO coverage indicated that NALICO's insurance was provided in accordance with ERISA. DX 24. Frank Kyle ("Kyle") was the insurance agent who assisted TOA members in obtaining coverage from NALICO. TR at 8-10.

On July 30, 1993, McNeil and Roy F. Dickey ("Dickey") formed a partnership known as "Drs. Dickey and McNeil, Optometrists" ("the Partnership"). TR at 86; DX 16 at 1, 12. The Partnership engaged in the business of selling eyeglasses which it purchased from suppliers all over the United States. TR at 88. In October of 1993, the Partnership hired Jana Jay ("Jay") as a full- time employee. Id. at 87-88.

In April of 1994, Kyle recommended that TOA members switch their coverage from NALICO to Time Insurance Company ("Time"). Id. at 18-19. Kyle sent to all TOA members, including McNeil, a summary of Time's benefits, the materials they needed to enroll, and a proposal ("the proposal") setting forth the cost of Time's insurance. Id. at 20, 22; DX 5. These materials were sent to McNeil and not to the Partnership, TR at 22, 51; DX 11, and the proposal did not mention ERISA. TR at 51; DX 11. After receiving these materials, McNeil telephoned Kyle to inform him that he had formed a partnership and wanted to add at least one employee to his coverage. TR at 24-25, 89-90, 100; DX 2. McNeil and Kyle discussed the coverage available for Jay, and McNeil

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[1] McNeil died on March 1, 1995. Since that time, Jimmy Wallace McNeil, individually and as independent executor of McNeil's estate, has prosecuted this action.

declined maternity coverage for her. TR at 25. Kyle explained to McNeil that he was required to pay seventy-five percent of the premium for his employees. Id. Following his conversation with McNeil, Kyle sent a second proposal which stated that McNeil and Jay would be covered by Time and their combined premium would be $237.66 per month. TR at 26-27; DX 12. According to Kyle, these materials did not constitute an ERISA plan. TR at 66, 70-71. Kyle did not market Time's insurance policy as an ERISA plan. Id. at 58-59.

Time's insurance policy was offered to TOA members through a Multiple Employer Trust ("Time MET"). Joint Pretrial Order at 3;[2] TR at 55-56. The Employer Participation Agreement/Application ("employer application") provided that the "employer adopts the Trust Agreement and agrees to be bound by all the terms and conditions of it and any amendments to it." DX 9 at 2. Kyle did not provide a copy of the Trust Agreement to McNeil or to the Partnership. TR at 56.

There are eighty-five groups with a total of approximately four-hundred individual members in the Time MET. TR at 72-73; Plaintiffs' Exhibits ("PX") 32-34. An individual member of the TOA with no employees could be covered under the Time MET. Joint Pretrial Order at 3; TR at 50. Such individual members would be known as "one life optometrist groups." Joint Pretrial Order at 3. Time agreed to insure these one-life groups in order to secure the patronage of the TOA. TR at 50-51; PX 35. Under Time's group policy, an "employer" can also be an "employee," and it was common for solo optometrists to use both terms to describe themselves when applying for coverage. TR at 47-48, 76. As an "employer," a solo optometrist wishing to obtain coverage from Time completed the employer application in order to sub-

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[2] Citations to the joint pretrial order refer to those facts stipulated by the parties as undisputed.

scribe to the MET. *Id.* at 61-62; DX 9. As an "employee," a solo optometrist completed the Group Insurance Employee Enrollment Form ("enrollment form"). *Id.* at 62- 63; DX10.

On April 27, 1994, McNeil, on behalf of the Partnership, submitted to Time an employer application, which indicated that the Partnership had three full-time employees but that only two sought medical insurance coverage. DX 9 at 1. By signing the employer application, McNeil agreed that he had the "authority to represent and bind the employer." *Id.* at 2. Kyle completed the portions of the employer application which selected medical coverage and the amount of annual and inpatient deductibles for that coverage. TR at 32. Shortly after McNeil submitted the employer application, he, Dickey and Jay each submitted enrollment forms. *Id.* at 29-30; DX 10, 13, 20. McNeil's enrollment form listed him as an "employee," described his job duties as "[p]artner in [b]usiness – [o]ptometrist," DX 10 at 1, and did not indicate that he agreed to establish or maintain an ERISA plan. TR at 64-65.

Upon accepting the Partnership's employer application and the enrollment forms from McNeil, Jay and Dickey, Time sent two documents to the Partnership-- certificate booklets for McNeil and Jay and an administrative kit ("the kit"). DX 17, 19; TR at 39-42, 152-53.[3] Time provided the kit "[t]o explain to the group how to administrate their group, how to file claims, various numbers to the insurance companies, all the things that we would ordinarily need to do in the course of a business to administrate their claim." TR at 42. The Partnership's administrative activity consisted of receiving premium notices, paying premiums, and, when Jay's employment ended, returning to Time her premium notice with a request to cancel her coverage. TR at 100-01, 141. Although the kit sent to the Partnership described the administrative duties it was to perform, Time did not know whether the Partnership performed any of these duties. *Id.* at 156-57. Time

[3] Dickey declined coverage from Time. TR at 106; DX 13.

investigated claims made pursuant to its insurance policy, determined eligibility for payment, notified the insured if coverage was to be cancelled, determined premium amounts, and decided whether the group policy's terms should be changed. *Id.* at 79-80. Time provided a telephone number for insureds to use if they had "any questions regarding [their] medical plan coverage...." PX 7. Time did not inform the Partnership that it had to administer an ERISA plan or other plan of insurance. TR at 120. Kyle believed Time to be the administrator of its group insurance policy. *Id.* at 81. The certificate booklets issued to McNeil and Jay stated that, "[a]s a participant under Your employer's plan, this certificate is being furnished in compliance with ... [ERISA]. Your employer is the plan administrator of this plan." DX 17.

On May 11, 1994, the Partnership paid the first premium to Time for McNeil and Jay from its operating account. TR at 99-100, 105, 130; DX 14. McNeil reimbursed the Partnership for his portion of this premium payment. TR at 133. Thereafter, in June, July, August, October, and November of 1994, the premium for Jay's insurance was paid separately from the premium for McNeil's insurance and was paid from the Partnership's account. DX 15; TR at 130-32. The premiums for McNeil and Jay were paid jointly in September of 1994, but McNeil later reimbursed the Partnership for his portion. DX 15 at 2; TR at 131. McNeil's funds, and not the Partnership's, were used to pay his premiums. TR at 133, 180.

McNeil did not intend to create, and did not understand himself to be the administrator of, an ERISA plan. TR at 178, 183. The Partnership did not intend to create a plan of insurance or an ERISA plan, nor did it draft a document called an ERISA plan. *Id.* at 116-18. The Partnership did not take any tax deductions for the costs of establishing or administrating an ERISA or other insurance plan, did not prepare or file any summary reports or financial reports for an ERISA plan, did not possess a summary plan description, and did not file any forms or reports regarding an ERISA plan with the Internal

Revenue Service ("IRS") or the United States Department of Labor ("DOL"). *Id.* at 112, 115-16, 126, 197-98, 201.

The Partnership dissolved on or about September 1, 1994. *Id.* at 127. Dickey paid Jay's premiums from November of 1994 to February of 1995, when Jay ceased to work for the Partnership. *Id.* at 135. In late 1994, after McNeil was admitted to the emergency room for treatment, Reviewtime, "the utilization review program of Time Insurance Company," sent him a notice which advised him to "direct questions regarding plan terms and limitations to Time Insurance Company Member Services Department." PX 23 at 2.

II. CONCLUSIONS OF LAW

An ERISA plan is any employee welfare benefit plan that is "established or maintained by an employer" engaged in interstate commerce[4] which "provid [es] for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment...." 29 U.S.C. §§ 1002(1), 1003(a)(1); see also *Gahn* v. *Allstate Life Insurance Company*, 926 F.2d 1449, 1451 (5th Cir. 1991).

The Fifth Circuit has

> devised a comprehensive test for determining whether a particular plan qualifies as an 'employee welfare benefit plan'; we ask whether a plan: (1) exists; (2) falls within the safe-harbor provision established by the Department of Labor; and (3) satisfies the primary elements of an ERISA 'employee benefit plan' – establishment or maintenance by an employer intending to

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[4] FN4. The court is satisfied, based upon the evidence adduced at trial, that the Partnership was "engaged in ... commerce" and "in an [ ] ... activity affecting commerce...." 29 U.S.C. § 1003(a)(1). The only case cited by the plaintiffs for the contrary proposition, *Sheffield* v. *Allstate Life Insurance Company*, 756 F. Supp. 309 (S.D.Tex.1991), see Plaintiffs' Closing Arguments and Trial Brief on ERISA at 35-36, is inapposite.

> benefit employees. If any part of the inquiry is answered in the negative, the submission is not an ERISA plan.

Meredith v. *Time Insurance Company*, 980 F.2d 352, 355 (5th Cir. 1993).

In this case, it is undisputed that a multiple employer trust exists and that the Time MET is not an ERISA plan. Joint Pretrial Order at 3. However, the relationship between Time and the Time MET is "only marginally relevant" to determining whether an ERISA plan exists. *Gahn*, 926 F.2d at 1452. The proper focus of the court's inquiry is "the employer ..., and [its] involvement with the administration of the plan." *Gahn*, 926 F.2d at 1452 (citing *Memorial Hospital System* v. *Northbrook Life Insurance Company*, 904 F.2d 236, 243 (5th Cir.1990), and *Taggart Corporation* v. *Life and Health Benefits Administration, Inc.*, 617 F.2d 1208, 1211 (5th Cir. 1980), cert. denied, 450 U.S. 1030, 101 S. Ct. 1739, 68 L. Ed.2d 225 (1981)). "The burden is on the [d]efendant ... to establish the existence of a plan or program which would invoke ERISA's exclusive remedy provisions, since it is the one asserting ERISA preemption." *Cooley* v. *Protective Life Insurance Company*, 815 F. Supp. 189, 194 (S.D.Miss. 1993) (citing *Kanne* v. *Connecticut General Life Insurance Company*, 859 F.2d 96, 99 n. 4 (9th Cir.1988), and *Murphy* v. *Inexco Oil Company*, 611 F.2d 570, 574 (5th Cir. 1980)).

A. Does A Plan Exist?

The initial inquiry as to whether there is a plan is governed by the test first articulated by the Eleventh Circuit in *Donovan* v. *Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*), and adopted by this circuit in *Memorial Hospital*, 904 F.2d at 240-241. The Eleventh Circuit's test is as follows:

> In determining whether a plan, fund or program (pursuant to a writing or not) is a reality a court must determine whether from the surrounding circumstances a rea-

> sonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.

Donovan, 688 F.2d at 1373. "A formal document designated as 'the Plan' is not required to establish that an ERISA plan exists." *Memorial Hospital*, 904 F.2d at 241. In addition, the purchase of an insurance policy does not, in and of itself, establish that a plan exists, " 'but the purchase is evidence of the establishment of a plan, fund, or program....' " *Id.* at 242 (quoting *Donovan*, 688 F.2d at 1373).

The court is of the opinion that a plan ("the plan") does exist in the instant case. A reasonable person could easily ascertain that the intended benefit of the plan purchased by the Partnership was medical insurance; that the beneficiaries were employees of the Partnership, *viz.*, McNeil and Jay; that the source of the financing was premiums paid by McNeil and the Partnership, and that the procedure for receiving benefits was to make a claim with Time through forms provided by it.

B. Is the Plan Excluded?

This part of the court's analysis focuses on whether the plan is exempt from ERISA because it falls within the safe-harbor provision promulgated by the DOL. 29 C.F.R. § 2510.3-1(j)(1)-(4); see also *Gahn*, 926 F.2d at 1452; *Memorial Hospital*, 904 F.2d at 241 n. 6. Under this provision, the insurance policy at issue is not an employee welfare benefit plan covered by ERISA if (1) the Partnership did not contribute to the policy; (2) participation was voluntary; (3) the Partnership's involvement with the policy was limited to collecting premiums and remitting them to Time and to permitting Time to advertise its policy; (4) the Partnership received no profit from administering the policy. *Gahn*, 926 F.2d at 1452; *Memorial Hospital*, 904 F.2d at 241 n. 6. "The plan must meet all four criteria to be exempt." *Meredith*, 980 F.2d at 355.

In the instant case, the evidence clearly shows that the Partnership paid for Jay's premium and thus did contribute to the plan. In addition, the evidence also shows that the Partnership was expected to be involved in the administration of the plan. See *McDonald* v. *Provident Indemnity Life Insurance Company*, 60 F.3d 234, 236 (5th Cir. 1995), *cert. denied*, 516 U.S. 1174, 116 S. Ct. 1267, 134 L. Ed.2d 214 (1996); *Sparks* v. *Life Investors Insurance Company of America*, 818 F. Supp. 945, 947-48 (N.D.Miss.1993). Accordingly, the plan falls outside the safe-harbor provision and is therefore not exempt from ERISA coverage.

C. Is the Plan an ERISA Plan?

The court now turns to the third step of its analysis to determine "whether the assumed plan falls within the broad parameters of ERISA." Meredith, 980 F.2d at 355. In making this determination, the court "look[s] to the two 'primary elements of an ERISA "employee welfare benefit plan" as defined by the statute: (1) whether an employer established or maintained the plan; and (2) whether the employer intended to provide benefits to its employees.' " *Id.* (quoting *MDPhysicians & Associates, Inc.* v. *State Board of Insurance*, 957 F.2d 178, 183 (5th Cir.), *cert. denied*, 506 U.S. 861, 113 S.Ct. 179, 121 L.Ed.2d 125 (1992), and *Hansen* v. *Continental Insurance Company*, 940 F.2d 971, 977 (5th Cir.1991)).

1. Establish or Maintain

To determine whether an employer established or maintained an employee welfare benefit plan, the court must focus on the employer and its involvement with the plan. *Gahn*, 926 F.2d at 1452. Although an employer's purchase of insurance does offer " 'substantial evidence' " that a plan has been established, *Memorial Hospital*, 904 F.2d at 242 (quoting *Donovan*, 688 F.2d at 1373), "if an employer does no more than purchase insurance for [its] employees, and has no further involvement with the collection of premiums, administration of the policy, or submission of claims, [it] has not

established an ERISA plan." *Hansen*, 940 F.2d at 978 (citations omitted).

The court is of the opinion that McNeil's purchase of insurance from Time was not a "bare purchase" of insurance so as to be beyond ERISA's purview. *Taggart*, 617 F.2d at 1211. The evidence developed during trial demonstrates that McNeil discussed the terms of Time's coverage with Kyle, was responsible for obtaining the plan from Time and for paying the premiums, and provided information as to the desired benefits and the employees to be covered. The evidence also shows that McNeil was sent the kit, which explained the duties he as the employer was to perform in administering the plan. Even if Time was primarily responsible for administering the plan, a fact for which there is some support in the record, "the fact that [the Partnership's] administrative functions under the policy are minimal is perfectly in keeping with its intent that [Time] administer the plan as well as insure it." *Memorial Hospital*, 904 F.2d at 243; see *Kidder* v. *H & B Marine, Inc.*, 932 F.2d 347, 352-53 (5th Cir. 1991) (relying on Memorial Hospital to conclude that an ERISA plan existed where employer contributed a portion of its employees' premiums but did not actively maintain or administer the insurance program). In addition, "[w]hether, in fact, [McNeil] ever performed any of the tasks outlined in the administration kit is irrelevant ...; by signing up to be a part of the trust, he was obligated to do more than simply collect and remit premiums." *Sparks*, 818 F. Supp. at 948. In short, McNeil established and maintained an employee welfare benefit plan. See *McDonald*, 60 F.3d at 236; *Hansen*, 940 F.2d at 978; *Memorial Hospital*, 904 F.2d at 242-43.

2. Intent to Benefit

"In addition to some meaningful degree of participation by the employer in the creation or administration of the plan, [ERISA] requires that the employer have had a purpose to provide health insurance, accident insurance, or other specified types of benefits to its employees." *Hansen*, 940 F.2d at

978 (citing 29 U.S.C. § 1002(1)). The court must find that the employer had an "intent to provide its employees with a welfare benefit program through the purchase and maintenance of a group insurance policy." *Memorial Hospital*, 904 F.2d at 241.

The court concludes that there was ample evidence presented at trial of McNeil's intent to provide health insurance for himself and for Jay. Specifically, Dickey and McNeil both decided to obtain health insurance for Jay and to pay the cost of such insurance, and McNeil notified Kyle that he had hired Jay and wished to provide such insurance for her. Further evidence of the Partnership's intent to benefit Jay is McNeil's discussion with Kyle about the cost of maternity coverage. Under controlling Fifth Circuit authority, that McNeil did not understand himself to be establishing an ERISA plan is of no moment; it is sufficient that he desired to provide a plan of health insurance for himself and his employee. *Meredith*, 980 F.2d at 354 ("We are not here concerned with whether the 'entity that established and maintained the plan intended ERISA to govern....' For our guidon we note that 'ERISA protection and coverage turns on whether the [plan] satisfies the statutory definition.'") (citing *MDPhysicians*, 957 F.2d at 183 n. 7); see also *Kidder*, 932 F.2d at 353 (finding that an ERISA plan exists because, "as in *Memorial Hospital* and unlike in *Taggart*, this case does not involve a company composed of a single employee who is essentially purchasing insurance for himself while attempting to characterize his insurance as a group health plan") (emphasis added).

In sum, the court is of the opinion that Time presented sufficient evidence of "an employer-employee-plan relationship" in the instant case, *Memorial Hospital*, 904 F.2d at 243, and thus discharged its burden of demonstrating the "existence of a plan or program which would invoke ERISA's exclusive remedy provisions." *Cooley*, 815 F. Supp. at 194.

D. ERISA Preemption

"It is well settled in the Fifth Circuit that 'state law claims, regardless of how they are pleaded, are preempted if they "relate to" an ERISA plan.'" *Davis* v. *AIG Life Insurance*, 945 F. Supp. 961, 967 (S.D.Miss.1995) (quoting *Epps* v. *NCNB Texas*, 7 F.3d 44, 45 (5th Cir. 1993), and citing *Hubbard* v. *Blue Cross and Blue Shield Association*, 42 F.3d 942, 945 (5th Cir.), *cert. denied*, 515 U.S. 1122, 115 S.Ct. 2276, 132 L.Ed.2d 280 (1995); *Rozzell* v. *Security Services, Inc.*, 38 F.3d 819, 821 (5th Cir. 1994), and *Iron Workers Mid-South Pension Fund* v. *Terotechnology*, 891 F.2d 548, 552 (5th Cir.), cert. denied, 497 U.S. 1024, 110 S. Ct. 3272, 111 L.Ed.2d 782 (1990)), *aff'd*, 85 F.3d 624 (5th Cir. 1996) (table). The Supreme Court "has interpreted ERISA's general preemption provision liberally: '[a] law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Memorial Hospital*, 904 F.2d at 244 (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S. Ct. 2890, 2900, 77 L. Ed.2d 490 (1983)).

The court concludes that the plaintiffs' state law claims – the gravamen of which is Time's failure to provide McNeil the maximum lifetime benefit set forth in his policy – address an area of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan, and directly affect the relationship between McNeil, the Partnership, and Time. *Smith* v. *Texas Children's Hospital*, 84 F.3d 152, 154 (5th Cir.1996). Accordingly, the plaintiffs' state law claims are preempted by ERISA. See *Pilot Life Insurance Company* v. *Dedeaux*, 481 U.S. 41, 43, 47-48, 107 S. Ct. 1549, 1550, 1552-53, 95 L. Ed.2d 39 (1987); *Hogan* v. *Kraft Foods*, 969 F.2d 142, 144-45 (5th Cir. 1992); *Lee* v. *E.I. DuPont de Nemours and Company*, 894 F.2d 755, 756, 758 (5th Cir. 1990); *Ramirez* v. *Inter-Continental Hotels*, 890 F.2d 760, 763-64 (5th Cir.1989); *Boren* v. *N.L. Industries, Inc.*, 889 F.2d 1463, 1464-65 (5th Cir. 1989), *cert. denied*, 497 U.S. 1029, 110 S. Ct. 3283, 111 L. Ed.2d 792 (1990); *Hermann Hospital* v.

MEBA Medical & Benefits Plan, 845 F.2d 1286, 1290-91 (5th Cir. 1988). In addition, none of the plaintiffs' state law claims falls under ERISA's savings clause, which exempts from preemption "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A); see *Pilot Life*, 481 U.S. at 50- 52, 107 S. Ct. at 1554-56; *Hogan*, 969 F.2d at 145 (citing *McManus* v. *Travelers Health Network of Texas*, 742 F. Supp. 377, 379-82 (W.D.Tex.1990)); *Ramirez*, 890 F.2d at 763-64.

III. CONCLUSION

Based on the findings of fact and conclusions of law set forth above, the court concludes that the insurance policy at issue in the instant case is governed by ERISA. The court also concludes that, because all of the plaintiffs' state law claims relate to that policy, these claims are preempted by ERISA.

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

JIMMY WALLACE McNEIL, Individually, and as Independent Executrix and representative of the ESTATE OF MICHAEL JAY McNEIL, Plaintiff,

VS.

TIME INSURANCE COMPANY, Defendant.

Civil Action No. 3:95-CV-0382-G

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
SEP 10 1997
NANCY DOHERTY, CLERK
BY _____ DEPUTY

ORDER

In accordance with the memorandum of decision of this date and the memorandum order of August 28, 1996, all of the plaintiff's claims, except those brought under the Employee Retirement Income Security Act (29 U.S.C. §§ 1001 *et seq.),* are **DISMISSED** with prejudice.

SO ORDERED.

September 10 , 1997.

A. JOE FISH
United States District Judge

APPENDIX H

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

JIMMY WALLACE McNEIL,)
Individually, and as Independent)
Executrix and representative of the)
ESTATE OF MICHAEL JAY McNEIL,) Civil Action No.
Plaintiff,) 3:95-CV-0382-G

VS.

TIME INSURANCE COMPANY,
Defendant.

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
DEC 18 1997
NANCY DOHERTY, CLERK
BY _____
DEPUTY

ORDER

Came on to be considered Plaintiffs Motion for Reconsideration, Motion for New Trial and/or to Amend or Alter September 10, 1997 Order and Final Judgment on Plaintiff's ERISA Claims, and the Court, having considered such Motion and the response thereto, is of the opinion that the Motion should be DENIED. Accordingly, it is

ORDERED, ADJUDGED and DECREED that Plaintiffs Motion for Reconsideration, Motion for New Trial and/or to Amend or Alter September 10, 1997 Order and Final Judgment on Plaintiff's ERISA Claims is hereby DENIED in all respects.

/s/ A. Joe Fish
JUDGE PRESIDING

APPENDIX I

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
DEC 18 1997
NANCY DOHERTY, CLERK
BY _____ DEPUTY

JIMMY WALLACE McNEIL, Individually, and as Independent Executrix and representative of the ESTATE OF MICHAEL JAY McNEIL, Plaintiff,	)	Civil Action No. 3:95-CV-0382-G
VS.	)	
TIME INSURANCE COMPANY, Defendant.	)	

ORDER ON MOTION TO DISMISS

Came on to be considered Time Insurance Company's Motion to Dismiss Claims in Third Amended Complaint Based Upon Alleged Failure to Follow Sound Actuarial Principles, and the Court, having considered such Motion and the response thereto, if any, finds and concludes that the Motion should be GRANTED. Accordingly, it is

ORDERED, ADJUDGED and DECREED that the Motion to Dismiss is GRANTED and Plaintiff's claims in the Third Amended Complaint based upon alleged failure to follow sound actuarial principles are hereby DISMISSED.

/s/ A. Joe Fish
JUDGE PRESIDING

APPENDIX J

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
APR 23 1998
NANCY DOHERTY, CLERK
BY _____ DEPUTY

JIMMY WALLACE McNEIL, Individually, and as Independent Executrix and representative of the ESTATE OF MICHAEL JAY McNEIL,
Plaintiffs,

v.

TIME INSURANCE COMPANY,
Defendant.

CIV. Action No. 3:95-CV-0382-G

ORDER GRANTING AGREED MOTION TO DISMISS AND ENTERING FINAL JUDGMENT

On the 23 day of April, 1998, came on to be considered Plaintiffs' Agreed Motion to Dismiss and Entering Final Judgment. The Court having reviewed the pleadings, considered the pleadings and evidence of the parties, the arguments and authorities, is of the opinion that Plaintiffs' Motion is well taken and should be granted.

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED that Plaintiffs' Agreed Motion to Dismiss and Entering Final Judgment is hereby granted and Plaintiffs' remaining claims for damages under ERISA are dismissed with prejudice.

IT IS, FURTHER, ORDERED, ADJUDGED AND DECREED that final judgment is hereby entered and Plaintiffs shall take-nothing by their claims against Defendant

Time Insurance Company. All court costs and attorney fees shall be paid by the party incurring the same.

SIGNED this 23 day of April, 1998.

/s/ A. Joe Fish
JUDGE PRESIDING

APPENDIX K

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

U.S. COURT OF APPEALS
FILED
JUN 28 2000

No. 98-10585

CHARLES R. FULBRUGE III
CLERK

MICHAEL JAY MCNEIL, ET AL
Plaintiffs

JIMMY WALLACE MCNEIL, as Independent Executor and Representative of the Estate of Michael Jay McNeil
Plaintiff - Appellant

v.

TIME INSURANCE COMPANY
Defendant - Appellee

Appeal from the United States District Court for the Northern District of Texas, Dallas

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ON PETITION FOR REHEARING AND REHEARING EN BANC

(Opinion 2/24/00, 5 Cir., ____, ____ F.3d, ____)

Before REYNALDO G. GARZA, JOLLY, and DEMOSS, Circuit Judges.

PER CURIAM:

(X) The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc, (FED.R.APP.P. AND 5TH CIR.R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) The Petition for Rehearing is DENIED and the court having been polled at the request of one of the members of the court and a majority of the judges who are in regular active service not having voted in favor, (FED.R.APP.P. AND 5TH CIR.R. 35) the Petition for Rehearing En Banc is also DENIED.

( ) A member of the court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor, Rehearing En Banc is DENIED.

ENTERED FOR THE COURT

/s/ E Grady Jolly

United States Circuit Judge

REHG-4A

CLERK'S NOTE: SEE FRAP AND LOCAL RULES 41 FOR STAY OF THE MANDATE

Supreme Court, U.S.
FILED
JAN 26 2001
OFFICE OF THE CLERK

No. 00- 848

IN THE

Supreme Court of the United States

JIMMY WALLACE MCNEIL, AS INDEPENDENT EXECUTOR AND REPRESENTATIVE OF THE ESTATE OF MICHAEL JAY MCNEIL,

Petitioner,

v.

TIME INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether Title III of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12182, governs the content of group insurance coverage when the same coverage is offered to all persons that apply.

2. Whether ERISA preempts state law claims based on a plan participants right to receive benefits under the ERISA plan.

STATEMENT PURSUANT TO RULE 29.6

Time Insurance Company states that its current name is Fortis Insurance Company (the name change was not the result of a transfer of assets or sale) and is a wholly owned subsidiary of Fortis, Inc., which is a wholly owned subsidiary of (1) Fortis (B) a foreign company that is traded on the Brussels, London and Luxemburg exchanges and (2) Fortis (NV) a foreign company that is traded on the Amsterdam, London and Luxemburg exchanges.

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The Respondent, Time Insurance Company ("Time"), respectfully requests that this Court deny the petition for writ of certiorari seeking review of the Opinion of the United States Court of Appeals for the Fifth Circuit in this case. That opinion is reported at 205 F.3d 179.

STATEMENT OF THE CASE

A. Factual Background.

McNeil was an optometrist who practiced in a partnership called Dickey & McNeil, Optometrists (the "Partnership") which was formed August 29, 1993. App. F2. The Partnership had an employee, its secretary Jana Jay. App. F2. In addition to treating patients, the Partnership also sold glasses to the public, and the glasses sold were shipped to the Partnership from all over the country. *Id.* The Partnership was a member of the Texas Optometric Association (the "Association"). *Id.* One of the benefits of membership in the Association was the ability to purchase group insurance offered to Association members. *Id.*

In April of 1994, McNeil received an informational brochure about health insurance coverage offered by Time to members of the Association. *Id.* The Time coverage was to replace coverage provided to Association members by National American Life Insurance Company of Pennsylvania ("NALICO"). App. F2. The brochure described the policy's benefits and limitations, including a limitation of coverage for acquired immune deficiency syndrome ("AIDS") of $10,000 during the first two years of coverage, and after the first two years, coverage up to the policy maximum of $2,000,000. App. D2.

McNeil, who had NALICO coverage from before the Partnership was formed, decided on behalf of the Partnership to purchase the Time plan to cover himself and the Partnership's employee, Ms. Jay. App. F2-F3. At McNeil's request, the agent soliciting the Time coverage sent McNeil a proposal which reflected that the Time coverage would apply to McNeil and Ms. Jay, that the Partnership had chosen not to provide maternity coverage, and that the premium would be $237 per month for both insureds. App. F3.

After receiving the proposal, McNeil completed the employer application for the Partnership and selected various options relating to the coverage for the employees such as the annual deductible amount, the rate of payment, and whether maternity coverage would be provided. App. F4. The agreement section of the employer application, which appears right above McNeil's signature, states, among other things,

> The employer understands that only full-time employees and their dependents are eligible for coverage. It is agreed that the employer will pay at least the required premium for the employees.

By signing the employer application, McNeil agreed and represented that he had "authority to represent and bind the employer." App. F4.

McNeil and Ms. Jay also mailed to Time employee enrollment forms which stated they were employees of the Partnership. *Id.* In response to medical questions on the enrollment form, McNeil represented that he had not been diagnosed with or treated for AIDS. Ms. Jay and McNeil were eligible for coverage only because they worked for the

Partnership and the Partnership applied for group coverage. App. F3. McNeil's partner, Dr. Dickey, did not enroll since he was covered by Medicare. App. A3.

Time accepted McNeil and Ms. Jay for coverage and certificate booklets evidencing the coverage were sent to the Partnership. App. F4. Time sent monthly premium notices, which always included both Ms. Jay and McNeil, to the Partnership. App. A3. The Partnership always paid the entire premium for Ms. Jay. App. A3. Consistent with the brochure, the certificate booklet set forth that, with respect to AIDS, there was a $10,000 maximum benefit during the first twenty-four months of coverage, and that thereafter the policy maximum would be applicable. App. D3. The certificate also limited benefits for various other conditions including psychiatric/substance abuse, temporomandibular joint dysfunction, and certain transplants. App. D8. The certificate form was approved by the Texas Department of Insurance on August 18, 1992. App. D3.

In September 1994, four months after the Time issued the coverage, McNeil was admitted to the hospital for treatment of an AIDS condition. App. A3. McNeil died on March 1, 1995, after incurring over $400,000 in medical expenses. App. A3. Consistent with the terms of the certificate, Time paid the first $10,000 of McNeil's medical expenses and denied the remaining claims under the terms of the certificate.

B. Disposition by the Courts Below.

Prior to his death, McNeil sued Time in Texas state court.[1] Time removed the case to federal court based upon ERISA preemption and diversity jurisdiction. In his original complaint, McNeil alleged common law causes of action of breach of contract, breach of the duty of good faith and fair dealing, negligent misrepresentations, waiver, estoppel and ratification, along with statutory violations of the Texas Deceptive Trade Practices Act ("DTPA"), Article 21.21 of the Texas Insurance Code and the Texas Commission on Human Rights Act.[2]

On May 10, 1995, Time filed its first motion for summary judgment arguing that McNeil's claims were preempted by ERISA and the Texas Commission on Human Rights Act claim was otherwise barred. On May 15, 1995, McNeil filed his first amended complaint which retained the same claims as the original complaint but added a claim under the ADA and an alternative claim for relief under ERISA. On May 30, 1995, Time filed a supplemental motion for summary judgment which addressed McNeil's claim under the ADA. Rather than rule on these pending motions, the Trial Court granted McNeil ninety days to conduct discovery on the ERISA issue and thereafter file responses to the pending motions for summary judgment.

---

1. The executor of McNeil's estate substituted in as plaintiff after McNeil's death. Throughout this brief, however, "McNeil" will refer to both McNeil and his estate.

2. McNeil did not appeal to the Fifth Circuit the Trial Court's dismissal of his claim under the Texas Commission on Human Rights Act and does not complain about the disposition of that claim in his Petition herein.

After discovery, Time filed its second supplemental motion for summary judgment on January 9, 1996, again arguing that ERISA governed the case and including additional facts obtained during discovery. On the same date, McNeil filed his response to the motion for summary judgment relating to the applicability of the ADA. On January 30, 1996, McNeil filed a second amended complaint that added no new causes of action but merely clarified prior allegations. On March 1,1996, Time filed its second motion for summary judgment arguing that the limitation of coverage for AIDS did not violate Texas law or ERISA. In response, McNeil argued that the limitation of coverage violated Texas Insurance Code Art. 21.21-3, Art. 21.21-6, and Art. 21.21 § 4(7)(b). McNeil also argued that the certificate was ambiguous and violated the ADA, and the limitation was therefore unenforceable.

On August 28, 1996, the Trial Court issued it memorandum order (1) granting Time summary judgment on McNeil's ADA claim and (2) denying Time summary judgment on ERISA. App. B. On April 3, 1997, the Trial Court issued its memorandum opinion granting Time's second motion for summary judgment, upholding the validity and enforceability under Texas law of the limitation on benefits for AIDS. App. D. After this ruling, McNeil filed a motion for reconsideration, which the Trial Court denied on June 12, 1997. App. E.

On June 24, 1997, the Trial Court held a bench trial limited solely to the question of whether an ERISA plan existed and therefore McNeil's remaining state law claims were preempted. On August 18, 1997, after the trial on the ERISA issue, McNeil filed his third amended complaint, which did not add any causes of action, but rather alleged

that several of the causes of action previously pled were supported by the factual allegation that the limitation of benefits for AIDS was "without a sound actuarial basis or actual or reasonably anticipated loss experience".

On September 2, 1997, Time filed a motion to dismiss the claims in the third amended complaint that were based upon an alleged failure to follow sound actuarial principles, arguing that (1) there was no support in Texas law for the claim, (2) the Trial Court had previously held that the limitation was enforceable under Texas law and the allegation was therefore untimely, and (3) the claim was preempted by ERISA since the actuarial claim was alleged within the rubric of causes of action that were preempted by ERISA.

On September 10, 1997, the Trial Court issued its memorandum order determining that ERISA governed the case and preempted McNeil's remaining state law claims. App. F. On the same date, the Trial Court dismissed all of McNeil's claims, other than claims under ERISA, with prejudice. App. G1. Nevertheless, the parties continued to brief the issue of whether McNeil's new factual allegation regarding actuarial soundness supported the causes of action pled. Indeed, in a joint status report filed by the parties on September 24, 1997, the parties listed various motions as pending, including Time's motion to dismiss claims based on alleged failure to follow sound actuarial principles.

On December 18, 1997, the Trial Court granted Time's motion to dismiss the actuarial claims and denied McNeil's motion for new trial and/or to amend or alter the September 10, 1997 order. App. I. On April 21, 1998, the parties filed an agreed motion to dismiss and request for entry of final judgment. Pursuant to the agreed motion, on April 23, 1998,

the Trial Court dismissed with prejudice McNeil's remaining claim for damages under ERISA and entered a final judgment that McNeil take nothing against Time. App. J.

McNeil appealed several of the Trial Court's rulings to the Fifth Circuit Court of Appeals. In addressing McNeil's complaints, the Fifth Circuit held that Time did not violate Texas Insurance Code Article 21.21-3 or Article 21.21.-4(7)(b). While questioning whether McNeil had stated a valid claim for failure to follow actuarial principles, the Fifth Circuit held that all the remaining claims were preempted since the claims were premised on an alleged failure to pay benefits under an ERISA plan. Finally, the Fifth Circuit held that Time did not violate the ADA since that statute does not govern the substantive terms of insurance policies when the same policy is issued to all applicants regardless of disability status.

REASONS FOR DENYING THE WRIT

A. The Fifth Circuit's Interpretation of the ADA is Consistent With the Interpretation of Every Other Circuit Court to Consider the Issue.

The issue presented is whether Title III of the ADA governs the content of insurance coverage when the same coverage is offered to all persons that apply. The import of Petitioner's argument is that Title III of the ADA prohibits "discrimination" in the content and design of goods and services offered by places of public accommodation, including the content and design of group insurance products purchased by employers. However, every Circuit Court that has ruled on this issue has ruled consistently with the Fifth Circuit that Title III of the ADA is inapplicable. *See Chabner*

v. United of Omaha Life Ins. Co., 225 F.3d 1042 (9th Cir. 2000); *Weier v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 528 U.S. 1106, 120 S. Ct. 845, 145 L. Ed. 2d 714 (2000); *Parker v. Metropolitan Life Insurance*, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084, 118 S. Ct. 871, 139 L. Ed. 2d 768 (1988); *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998), *cert. denied*, 525 U.S. 1092, 119 S. Ct. 850, 142 L. Ed. 2d 704 (1999). In *Doe*, a case virtually identical to this one, the Seventh Circuit held consistently with the Fifth Circuit that:

> Section 302(a) does not require a seller to alter his product to make it equally valuable to the disabled and to the non-disabled, even if the product is insurance.

Doe, 179 F.3d at 563. The Seventh Circuit went on to note that its "conclusion is consistent with all the appellate cases to consider this or cognate issues." *Id.* (citations omitted). Importantly, this Court declined to review *Doe*.

The Fifth Circuit's holding is also consistent with pronouncements by this Court and other Circuit Courts that a uniformly applied limitation of benefits is not discriminatory. In the present case, the evidence is uncontroverted that Time provided the same coverage to all those who were eligible, including McNeil. In a similar context, the court in *EEOC v. CNA Ins. Co.*, 96 F.3d 1039 (7th Cir. 1996) stated:

> There is no claim here that CNA discriminated on the basis of disability in offering its Pension Plan to anyone. It did not charge higher prices to

> disabled people, on the theory that they might require more benefits. Nor did it vary the terms of its Plan depending on whether or not the employee was disabled. All employees — the perfectly healthy, the physically disabled, and the mentally disabled — had a Plan that promised them long-term benefits from the outset of disability until age 65 if their problem was physical, and long-term benefits for two years if the problem was mental or nervous. This may or may not be an enlightened way to do things, but it is not discriminatory in the usual sense of the term.

Id at 1044. (addressing a claim under Title I of the ADA) (citation omitted). *See also Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712 (1985) (decided under the Rehabilitation Act); *Parker* 121 F.3d at 1015-19; *Stoutenborough v. NFL*, 59 F.3d 580 (6th Cir.) *cert. denied*, 116 S. Ct. 674 (1995); *Modderno v. King*, 82 F.3d 1059 (D.C. Cir. 1996), *cert. denied*, 117 S. Ct. 772 (1997). As noted in *Modderno*, "as long as the [benefit plan] offers the same coverage to all insureds, regardless of disability, it cannot be said to discriminate on the basis of disability." *Modderno*, 82 F.3d at 1066 (Judge Ginsberg concurring). Here, Time offered the same coverage to everyone, and therefore its conduct is not discriminatory "in the usual sense of the term." *CNA*, 96 F.3d at 1044.

The Fifth Circuit's holding is similarly consistent with regulations, applicable to all businesses, promulgated under Title III, which provide:

> This part does not require a public accommodation to alter its inventory to include accessible or

> specialty goods that are designed for, or facilitate use by, individuals with disabilities.

28 C.F.R. § 36.307(a). Thus, Title III does not require all American businesses that are considered "public accommodations" to enter specialty markets. *See* 28 C.F.R. § 36.307(c). Similarly, consistent with the decisions of every Circuit Court to address the issue, Title III cannot reasonably be interpreted to require health insurers to fund all range of potential insureds' risks, particularly when the same coverage is issued to all who apply. Indeed, to adopt McNeil's proposed interpretation would convert Title III of the ADA from a guaranty of access to a mandated benefits provision in relation to the insurance industry. The effect of McNeil's proposed interpretation is that an insurance company would be required to provide coverage for every condition that could potentially be disabling. As determined by every Circuit Court to address the issue, the ADA simply does not mandate such a result.[3]

Further, in refusing to follow the Department of Justice's administrative pronouncements interpreting the ADA to apply to the content of insurance policies, the Fifth Circuit followed the lead of the Seventh, Sixth, and Third Circuits, which also rejected the DOJ's interpretation because it conflicted with the express language of the ADA. *See Doe*, 179 F.3d at 562-63; *Ford*, 145 F.3d at 613 ("[the DOJ's] interpretation is 'manifestly contrary' to the plain meaning of Title III and,

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3. Such a result would also disrupt the expectations of the parties since insurance products are priced, on a class basis, envisioning coverage for only the specific risks set out in the policy. Requiring additional coverage to already issued policies would force a complete repricing of the coverage for all insureds.

accordingly, is not binding on this Court"); *Parker*, 121 F.3d at 1012 n.5 ("As [the DOJ's] interpretation is inconsistent with its regulations and the statutory text of Title IV, we decline to adopt it"). The Fifth Circuit's Opinion in this case, holding that Title III does not govern the content and design of insurance policies, as well as the content and design of other goods offered for sale by places of public accommodation, is consistent with the holdings of the other Circuit Courts to address the issue.

McNeil concedes (Petition, p. 9) that the decision below is consistent with the decisions of the Third, Sixth, Seventh, and Ninth Circuits. He argues, however, that it is inconsistent with the standard adopted in *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28 (2d Cir. 2000). But in *Pallozzi*, the issue presented in this case was never even addressed.[4] In this regard, *Pallozzi* involved an insurance company that had refused to sell a life insurance policy, without explanation, to a disabled individual. In concluding that Title III could apply to a refusal to sell insurance to a disabled individual, the Second Circuit did not have occasion to decide whether Title III regulated the content of the insurance to be sold. Indeed, the Second Circuit relied, at least in part, on the Seventh Circuit's opinion in *Doe*, which specifically held, on facts virtually identical to this case, that Title III does not regulate the content and design of insurance policies. *Pallozzi*, 198 F.3d at 33. The Second Circuit summarized its holding by stating:

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4. Time respectfully disagrees with the Fifth Circuit's statement that "the Second Circuit read Title III to regulate content as well as access." App. A14. As set forth herein, *Pallozzi* dealt strictly with access to insurance. In the Fifth Circuit's defense, *Pallozzi* was decided after briefing had closed in this case, and therefore Time did not address this distinction in its brief.

> We believe an entity covered by Title III is not only obligated by the statute to provide disabled persons with physical access, but is also prohibited from refusing to sell them its merchandise by reason of discrimination against their disability.

Id. citing Doe v. Mutual of Omaha, 179 F.3d at 559, 564. The Second Circuit did not hold that the ADA controlled the terms of the policy to be sold. While McNeil alleges disagreement among the district courts on this issue, resolving disagreements among district courts is the function of the Courts of Appeals, not this Court. Since there is no conflict among the Circuit Courts on the issue of whether Title III governs the content and design of insurance policies when the same coverage is offered to all, certiorari should be denied.

B. The Fifth Circuit's Preemption Analysis Under ERISA is Consistent With This Court's Prior Opinions.

McNeil argues that the state law claims he asserted are not preempted by ERISA. However, McNeil curiously fails to identify the claims he is referencing. As noted above, his claim under Texas Insurance Code Art. 21.21-3 and Art. 21.21 § 4(7)(b) were addressed on the merits. Further, the Fifth Circuit, in addressing McNeil's claim that the policy failed to follow sound actuarial principles, specifically determined that the Texas Administrative Code provisions relied on by McNeil "do not provide the foundation for a claim." *See* App. A20 n.21. As noted by the Fifth Circuit, the claims that were not addressed on the merits and were found to be preempted were: breach of contract, breach of the duty of good faith

and fair dealing, negligent misrepresentation, common law discrimination, waiver, estoppel and ratification, and his claim that various provisions of the Texas Insurance Code requiring sound actuarial principles are incorporated into state contract law and tort law (under the duty of good faith and fair dealing) when insurance is involved. *See* App. A20. Further, the foundation of all of these claims was McNeil's right to receive benefits under an ERISA plan. *See* App. A21.

Consistent with this Court's prior guidance, the Fifth Circuit preempted the claims because they were based on McNeil's right to receive benefits under the terms of an ERISA plan. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987). McNeil does not argue that another Circuit Court has concluded that preemption is not warranted under these circumstances since the Circuit Courts are in agreement in this issues. *See, e.g.*, *Algren v. Pirelli Armstrong Tire Corp.*, 197 F.3d 915 (8th Cir. 1999) (estoppel claim preempted by ERISA); *Kolasinski v. Cigna Healthplan of CT, Inc.*, 163 F.3d 149 (2d Cir. 1998) (breach of contract and unfair trade practices claims arising out of failure to pay benefits are preempted by ERISA); *McMahon v. Digital Equipment Corp.*, 162 F.3d 28 (1st Cir. 1998) (claims for breach of contract, negligent administration, and unfair trade practices are preempted by ERISA); *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003 (9th Cir. 1998) (Washington Insurance Code and Washington Consumer Protection Act claims, as well as claims for breach of contract and negligence, preempted); *White v. Provident Life & Acc. Ins. Co.*, 115 F.3d 26 (4th Cir. 1997) (waiver and estoppel claims preempted by ERISA). Nor does McNeil explain how the analysis regarding ERISA preemption in relation to his specific claims is somehow altered by *New York Conference of Blue Cross and Blue*

Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). McNeil is, in reality, arguing for a reassessment of all preemption analysis under ERISA going back to *Pilot Life*. Time submits that such a reassessment is not only unwarranted, but is inappropriate given the specific claims asserted by McNeil that were determined to be preempted by the Fifth Circuit in this case.[5]

Although McNeil argues that the decision below misinterpreted *Travelers* and *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999), he points to no decision of any Court of Appeals holding similar claims not to be preempted. In fact, there are none. At most, McNeil argues that *Travelers* and *Unum* were incorrectly applied to the facts of this case. Such a fact bound claim does not warrant this Court's review.

Similarly, McNeil's argument that the Fifth Circuit misapplied the ERISA Savings Clause, 29 U.S.C. § 1144(b)(2)(A), at best overstates his case. In this regard, McNeil argues that "each of the laws relied upon," both statutory and common law, are saved from preemption. *See* Petition, p.19. However, each of McNeil's claims based on Texas Insurance Code provisions and regulations were disposed of by the Fifth Circuit on the merits. This is not surprising since the Trial Court also addressed these claims on the merits. Specifically, prior of the Trial Court holding that ERISA was applicable to the case, it had already ruled that the limitations on benefits for AIDS was valid and

5. Time would note that the claims have questionable viability regardless of preemption. The Fifth Circuit determined that the limitation on coverage, which formed the basis of Time's denial of benefits, was valid and enforceable, and McNeil's claims were predicated on a wrongful failure to pay benefits.

enforceable under Texas law, despite the statutory and common law claims asserted by McNeil. *See* App. D1. Since the Trial Court addressed such claims on the merits, the Fifth Circuit did so as well. *See* App. A4, n.1. Once the Fifth Circuit determined, as did the Trial Court, that the limitation on benefits was valid and enforceable under Texas law, the only remaining issue, as explicitly recognized by the Fifth Circuit, was McNeil's "right to receive benefits under the terms of an ERISA plan." App. A21. Under this Court's holding in *Pilot Life* such claims are not saved from preemption, particularly given "congressional intent that ERISA's civil enforcement scheme be exclusive." *Pilot Life*, 107 S. Ct. at 1555-1558.[6]

Finally, McNeil asserts that the Fifth Circuit employed an overbroad definition of interstate commerce in determining that ERISA was applicable. The Fifth Circuit's analysis is consistent with the terms of ERISA and this Court's prior pronouncements. This Court has long recognized that the use of the term "activity affecting commerce" manifests a congressional intent to regulate "within the full sweep of its constitutional authority." *Polish Nat. Alliance of the U.S. v. NLRB*, 322 U.S. 643, 647, 64 S. Ct. 1196, 1198 (1944). Since the evidence established that the Partnership sold goods, such as glasses, which were shipped to the Partnership from all over the Country, it was engaged in interstate commerce sufficient to bring the plan squarely within the parameters of ERISA. *See* 29 U.S.C. § 1002(11) and (12). This fact bound determination does not warrant review by this Court.

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6. McNeil asserts that the Court's disposition in *Egelhoft*, No. 99-1529, could somehow effect this case. However, *Egelhoft* does not involve ERISA's civil enforcement scheme and therefore, would not effect the Fifth Circuit's decision in this case.

CONCLUSION

For the reasons stated, the petition for the writ of certiorari should be denied.

Respectfully submitted,

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IN THE

Supreme Court of the United States

JIMMY WALLACE MCNEIL,
as Independent Executor and Representative of the Estate of Michael Jay McNeil,

Petitioner,

v.

FORTIS INSURANCE COMPANY
(f/k/a TIME INSURANCE COMPANY),

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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Respondent.

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REASONS FOR GRANTING THE WRIT

I. THE FIFTH CIRCUIT'S RESTRICTIVE INTERPRETATION OF THE ADA CONFLICTS WITH THE DECISIONS OF OTHER COURTS AND IS WRONG.

A. There Is a Circuit Split Regarding Title III's Application to Insurance.

Though erring on the merits, the Fifth Circuit correctly recognized that its views were fundamentally incompatible with the views of the Second Circuit in *Pallozzi* v. *Allstate Life Ins. Co.*, 198 F.3d 28, 32 (CA2 2000) (as amended). App. A14-15. Respondent nonetheless argues that there is no conflict between the Fifth and Second Circuits because *Pallozzi* addressed only access to insurance, whereas the decision

below deals with discriminatory terms of an insurance policy. BIO 11. Not only does that argument ignore the language and reasoning of the *Pallozzi* decision, it also posits a false dichotomy between equal access by the disabled to a policy itself and equal coverage of the disabled for identical treatments under such a policy.

Pallozzi held that the ADA's § 501(c) safe-harbor provision, 42 U.S.C. § 12201(c) – applicable to "underwriting risks, classifying risks, or administering risks" consistent with state law – necessarily implied ADA coverage of "insurance underwriting practices" that fell outside the bounds of that safe harbor. 198 F.3d at 32. While the facts of *Pallozzi* itself dealt with one aspect of underwriting, classifying, and administering risks – the refusal to sell a policy at all to certain groups – the Fifth Circuit correctly recognized that underwriting, classifying, and administering risks are also necessarily reflected in the *substance* of a policy. App. A12 n.10. The Fifth Circuit's refusal to apply the ADA to underwriting decisions reflected in disability-based coverage limitations thus necessarily contradicts the Second Circuit's holding that the ADA does apply to underwriting decisions. That such underwriting decisions in *Pallozzi* were implemented at the point of sale rather than incorporated into the limitations of the policy itself is immaterial to the legal analysis based on the safe-harbor of § 501(c). Indeed, recognizing that § 501(c) provided only limited protection for "the content" of insurance policies, the Fifth Circuit could reach its result only by holding, contrary to the Second Circuit, that the safe-harbor provision was essentially meaningless surplus providing an oddly "partial[]" exemption from a supposedly incorrect interpretation of Title III. App. A12 n.10.

These divergent views of the import of the safe-harbor provision are the core of the split between the Fifth and Second Circuits. Either discriminatory underwriting decisions outside the safe harbor are covered by Title III or they are not. Whether such discriminatory decisions are reflected in limi-

tations on sales or in limitations on coverage is immaterial to the legal question dividing the circuits.

Respondent's emphasis that several other circuits have reached the same result as the Fifth Circuit at most suggests an imbalance in the breakdown of the split, not the absence of a split.[1] That the Fifth Circuit has a certain amount of company in its error only demonstrates the importance of the issue and the greater need for correction by this Court. Furthermore, the disagreement and confusion among federal judges is deeper than is reflected by the circuit count alone. For example, the Sixth Circuit's *en banc* decision in *Parker* v. *Metropolitan Life Ins. Co.*, 121 F.3d 1006 (CA6 1997), *cert. denied*, 522 U.S. 1084 (1998), was bitterly divided, with the Chief Judge and four others dissenting based on their correct view of the § 501(c) safe harbor. *Id.* at 1008, 1019-21. And a plethora of district court judges have not only agreed with petitioner's position, but found that result to be plain from the language of the statute. See Pet. 10-11 (citing cases). These additional conflicting views highlight both the frequency and importance of this issue and the depth of confusion regarding two incompatible, yet simultaneously "plain," readings of the ADA's language. Such a divergence of views among federal judges at both the circuit and district levels calls for this Court's intervention. See STERN, GRESSMAN, SHAPIRO & GELLER, SUPREME COURT PRACTICE § 4.6, at 177 (7th ed.1993) (discussing significance to certiorari decision of closely divided *en banc* decisions and citing cases); *id.* § 4.8, at 179 (discussing significance of district court decisions as part of a broader conflict and citing cases).

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[1] And while the Seventh Circuit's opinion in *Doe* v. *Mutual of Omaha Ins. Co.*, 179 F.3d 557 (CA7 1999), *cert. denied*, 120 S. Ct. 845 (2000), was cited by the Second Circuit in *Pallozzi*, 198 F.3d at 31-32, it was cited for the proposition that the ADA *did* extend to the refusal to sell insurance, not for the Seventh Circuit's contradictory further proposition that the ADA did not extend to the content of insurance policies.

B. The Exclusion of Discriminatory Insurance Terms from Coverage under Title III Is Erroneous.

Ignoring the flaw in defining a good or service in terms of the forbidden discrimination itself, Pet. 11-13, respondent continues the conceptual error of the Fifth Circuit by misstating the question presented as whether Title III governs the content of insurance "when the same coverage is offered to all persons that apply." BIO i. The problem, of course is that the "same coverage" is not offered to "all persons" where the policy itself incorporates an exclusion expressly targeted to only some persons with a particular disability. As this Court held in *Alexander* v. *Choate*, 469 U.S. 287, 301 n.21 (1985), "[t]he benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled * * *." (Citation omitted).

This basic conceptual issue was raised during the January oral argument in *PGA Tour* v. *Martin*, No. 00-24. There, the questioning turned to whether any given "rule" was essential to the game of golf, and hence was an intrinsic part of the privilege or advantage being offered by a public accommodation. But there, the rules were facially neutral requirements having a disparate impact on persons with certain types of disabilities, *not* express exclusions or limitations based on a disability itself. Thus, while walking may be harder (or even impossible) for the disabled, that may well be part of the game of golf as defined by the promoter of the game. But there seems little doubt that a rule keyed directly to a disability – hypothetical Rule 22: A golfer must not have a physical handicap – would not be permissible. The essential distinction when it comes to intangible goods or services that are otherwise defined by the provider is that the protected trait – disability, race, etc. – cannot be the *trigger* for the rule,

whereas facially neutral rules may be allowed to have disparate impacts in many cases.[2]

Respondent's concern over petitioner's supposed effort to require insurers to offer *different* goods or services that would better suit the disabled thus misses the point. Petitioner merely sought access to the exact same coverage for the exact same treatments available to non-disabled persons. Time's policy already covered treatment for pneumonia and cancer up to a million dollars, but then denied that very coverage for *identical treatment* to persons also disabled with AIDS. This case is not about whether an insurance policy is required to cover a particular drug or a particular treatment for AIDS itself. Rather, this case is about whether Time, whose policies indisputably cover treatment of pneumonia and cancer, may nonetheless limit coverage for such otherwise available treatment for the sole reason that the insured also is disabled with AIDS. There is no attempt to obtain coverage different that that provided the non-disabled, but rather to have the *same* treatments for pneumonia and cancer covered *regardless* of whether the insured is disabled.

The distinction between defining a product to contain limited substantive coverage and discriminating based on disability by selectively limiting *who* may access otherwise available coverage was expressly addressed in the legislative history regarding Title I of the ADA. Any limitations or exclusions in coverage provided through employment must ap-

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[2] Insofar as the *PGA* case is likely to discuss how one defines the baseline product or service, whether a particular criteria is fundamental to that product or service, and thus whether its removal would constitute a "different" product, it might be appropriate to hold this petition for that *PGA* decision. On the other hand, this petition provides an excellent vehicle and a useful concrete example for discussing what is fundamental in a product given that sound actuarial principles and state law are the dispositive determiners of what is fundamental to an insurance product. It is undisputed that respondent's limitation on coverage for persons with AIDS was *not* based on sound actuarial principles.

ply equally to all employees, not simply to those employees with a particular disability or illness:

> A limitation may be placed on the types of drugs or procedures covered[,] *e.g.*, a limit on the number of x-rays or non-coverage of experimental drugs or procedures; but, that limitation must apply to persons with or without disabilities. All persons with disabilities must have equal access to the health insurance coverage that is provided by the employer to all employees.

S. REP. No. 101- 116, at 29 (1989). In this case, respondent did not limit coverage for a particular treatment or procedure but rather imposed a disability-based limitation that provided different persons with different coverage for the same treatment or procedure. That is forbidden discrimination.

II. THE DECISION BELOW CONFLICTS WITH DECISIONS FROM THIS COURT AND NUMEROUS OTHER COURTS RECOGNIZING THE MUCH-NARROWED SCOPE OF ERISA PREEMPTION.

It is undisputed that the Fifth Circuit's dismissal of *Travelers* and its progeny conflicts with the sweeping effect given those cases by numerous other courts. Pet 16-17. Unable to defend the Fifth Circuit's cavalier disregard for *Travelers*, respondent instead claims that it does not matter because most of the state-law claims would have been preempted anyway and two others were rejected on the merits. BIO 12-13.

First, given that the Fifth Circuit never bothered to engage in the required analysis, respondent's claim of harmlessness is pure speculation. Furthermore, as explained in the petition, state-law regulation of a product in the market – here a health care insurance product – applicable regardless of whether that product is purchased by an ERISA plan or by an individual, is precisely the type of neutral regulation that *Travelers* held was not preempted under a proper "connection" analysis. Pet.

17-18. [3] The cases respondent cites to suggest that the result would be the same are, on the whole, inapposite, with most not even citing *Travelers* or its progeny. Respondent's only case citing *Travelers*, *Bast* v. *Prudential Ins. Co.*, 150 F.3d 1003, 1007-08 (CA9 1998), *cert. denied*, 528 U.S. 870 (1999), merely recites the *Travelers* test and then proceeds to ignore it and rely on questionable applications of pre-*Travelers* case-law. And *Bast*'s analysis of the insurance savings clause fairly well flies in the face of *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 742-43 (1985). Suffice it to say that such questionable analysis from the Ninth Circuit falls far short of demonstrating that the Fifth Circuit's erroneous methodology was harmless.

Second, although petitioner sought remedies under a variety of legal theories, each claim at issue here was based upon a duty imposed by state insurance law, and hence each is preserved by the insurance savings clause. Pet. 18-19. In most instances, that duty was respondent's insurance-specific obligation to base the terms and limitations of its insurance policies on sound actuarial principles. Regardless of whether the breach of that duty is conceptualized as a tort, as a contract action incorporating the state-law insurance duty, or as a statutory cause of action under specific remedial provisions of the insurance code, the result is the same: the underlying duty is a specific regulation of insurance and thus is not preempted by ERISA. The foundation of these claims in not, as respondent would have it, a right to receive ERISA benefits, but rather a prior right to be free from unlawful insurance prac-

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[3] The relevance of this Court's upcoming decision in *Egelhoff* v. *Egelhoff*, No. 99-1529, is that the opinion will likely discuss the proper application of the *Travelers* test, and in particular the "connection" aspect of that test. While the factual scenarios differ, the clarification of the relevant legal principles in *Egelhoff* could easily have a bearing on the approach used in this case. A hold for *Egelhoff* thus might be appropriate.

tices *regardless* of whether the insurance is purchased by an ERISA plan or otherwise.[4]

As in *Unum Life Insurance Co. of America* v. *Ward,* 526 U.S. 358 (1999), even direct contract actions are saved from preemption where the contractual duty or defense alleged is one that is unique to insurance. In *Unum* it was a notice-prejudice rule entitling the claimant to recover benefits despite the lack of notice. 526 U.S. at 371 ("notice- prejudice rule is distinctive most notably because it is a rule firmly applied to insurance contracts, not a general principle guiding a court's discretion in a range of matters"). Here, it is an incorporated obligation that policy limits be based on sound actuarial principles, barring the insurer from applying a policy limit not so based.[5]

Finally, as noted in the petition, Pet. 7 n.3, and never disputed by respondent, the Fifth Circuit's rejection on the merits of two state-law discrimination claims was inextricably bound up with the court's error regarding discrimination under the ADA, and hence those determinations are neither adequate nor independent grounds if this Court finds for petitioner on the issue of discrimination under the ADA. The proper methodology for and scope of ERISA preemption thus would be important for those two claims as well on remand.

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[4] In this sense the basic right to a lawfully configured insurance product is no different than the right to have medical care or child care comply with uniform state laws, regardless of whether an ERISA plan or somebody else is paying for such care.

[5] As it appears that this Court is considering revisiting the application of ERISA's insurance savings clause, *see Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665 (*cert.* filed Oct. 24, 2000) (views of the United States invited, Jan. 8, 2001), the application of that clause in this case may provide an useful vehicle to that end, or may be affected by the *Montemayor* case should the Court decide to grant that petition.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted. Alternatively, this petition should be held for any or all of *Egelhoff* v. *Egelhoff*, No. 99-1529, *PGA Tour* v. *Martin*, No. 00-24, and *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665.

Respectfully submitted,

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